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ROYAL COMMISSION OF INQUIRY INTO CERTAIN
DEATHS AT THE HOSPITAL FOR SICK CHILDREN AND
RELATED MATTERS.

Hearing held
8th floor
180 Dundas Street West
Toronto, Ontario

The Honourable Mr. Justice S.G.M. Grange	Commissioner
P.S.A. Lamek, Q.C.	Counsel
E.A. Cronk	Associate Counsel
Thomas Millar	Administrator

Transcript of evidence
for

3 May 1984

VOLUME 140

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AND RELATED MATTERS.

Hearing held on the 8th Floor,
180 Dundas Street West, Toronto,
Ontario, on Thursday, the 3rd day
of May, 1984.

THE HONOURABLE MR. JUSTICE S.G.M. GRANGE - Commissioner
THOMAS MILLAR - Administrator
MURRAY R. ELLIOT - Registrar

APPEARANCES:

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E. CRONK)	
D. HUNT)	Counsel for the Attorney
L. CECCHETTO)	General and Solicitor General
	of Ontario (Crown Attorneys
	and Coroner's Office)
I.J. ROLAND)	Counsel for The Hospital for
M. THOMSON)	Sick Children
D. YOUNG	Counsel for The Metropolitan
	Toronto Police
W.N. ORTVED	Counsel for numerous Doctors
	at The Hospital for Sick
	Children
B. SYMES)	Counsel for the Registered
E. McINTYRE)	Nurses' Association of Ontario
	and 35 Registered Nurses at
	The Hospital for Sick Children

(Cont'd) ..



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APPEARANCES: (Cont'd)

D. BROWN	Counsel for Susan Nelles - Nurse
G.R. STRATHY) P. RAE)	Counsel for Phyllis Trayner - Nurse
J.A. OLAH	Counsel for Janet Brownless - R.N.A.
S. LABOW	Counsel for Mr. & Mrs. Gosselin, Mr. & Mrs. Gionas, Mr. & Mrs. Inwood, Mr. & Mrs. Turner, Mr. & Mrs. Lutes; and Mr. & Mrs. Murphy (parents of deceased children)

VOLUME 140



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BmCB.jc
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--- Upon commencing at 10:00 a.m.

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THE COMMISSIONER: Before we start

this morning I have two statements as to matters arising out of the recent decision of the Court of Appeal. The first one relates to Phase I. I do not intend to seek leave to appeal to the Supreme Court of Canada. The overriding reason relates to time. There will be no resolution of an appeal for many months, even years, and the only practical and indeed the only lawful course for the Commission, while an appeal was pending, would be to proceed with evidence, argument and the preparation and delivery of the report in accordance with the law as it now stands. It would be very, very difficult to reopen the matter should the law change in the Supreme Court of Canada.

If an application for leave is made by others, Counsel for the Commission may point out the practical difficulties and may ask whether leave be granted, the appeal be expedited, but otherwise we will neither support nor oppose the application. If leave should be granted Counsel for the Commission will support the appeal.

On the question of funding of an application I do not think I should determine the matter because I may be seen to have a conflict of



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interest. The same thing may apply to the obvious alternative, namely, the Attorney General. So, therefore, anyone who seeks funding I will ask the Attorney General to agree with me on an independent person who will be the final arbiter of whether funding should be extended.

On Phase II the question for next Wednesday as I see it is this: Can I, in light of the recent Decision of the Court of Appeal, receive evidence or submissions or report on the propriety or otherwise of the conduct of any person in the course of the investigation and prosecution. To cite only one example, this might encompass anything that tends to show either negligence or malice or the lack of it on the part of the Attorney General or his servants, Crown Counsel, or of the Police, who are all sued in a pending action by Susan Nelles.

If any party should argue that the answer to the question is no or that the issue is in doubt, he may also make submissions on what action can or should be taken to remedy the matter.

If time permits on that day, that is next Wednesday or whenever it should be heard, and in any event on some day if we are to proceed with Phase II I will have to consider the standing of



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parties in that phase. It seems clear that standing should be granted to Susan Nelles, to the Attorney General and the Solicitor General, to the Metropolitan Toronto Police and to the Hospital if they seek it. Any other party with standing in Phase I or indeed any other person who seeks standing in Phase II I will hear their representations at that time.

I have already indicated to Counsel for the Police, and I now say it to Counsel for the Attorney General, that it would be helpful to hear something on the positions they intend to take in Phase II with respect to the conduct of persons other than their own clients because that may well affect my decision on the question of standing.

Now, I will answer any questions if anybody has any but if not - Yes, Mr. Brown?

MR. BROWN: The date Wednesday is increasingly being taken as a fixed date. I take it that is subject to Mr. Sopinka's availability?

THE COMMISSIONER: No, the reason I make this statement now is in case we proceed on Wednesday you will have had adequate notice of what the problem is.

MR. BROWN: I appreciate that.

THE COMMISSIONER: And as soon as you



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and Mr. Young or your leaders can let us know the
happier we will be.

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I take it, Mr. Hunt, you are available
on Wednesday, are you?

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MR. HUNT: Yes.

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THE COMMISSIONER: And I take it that
Mr. Scott or Mr. Roland are available?

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MS. THOMSON: Yes, sir.

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THE COMMISSIONER: All right. Well
now, I guess we could have the witness up, could we?

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GLORIA BUCCI, resumed

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THE COMMISSIONER: I guess, Mr. Brown,
you are next.

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CROSS-EXAMINATION BY MR. BROWN:

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Q. Mrs. Bucci, my name is Brown
and I act for Miss Susan Nelles.

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During the time that you worked on
the cardiac ward from approximately April, 1980 until
slightly after March, 1981 I take it that you had
occasions to work with Miss Nelles on that floor,
did you not?

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A. Yes.

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Q. And by my count, although don't
hold me to it, you worked with her approximately 17
times on the same shift?



A.5

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A. All right.

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Q. Okay. And during that time what opinion did you form of Miss Nelles' abilities as a nurse?

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A. I thought she was a very good nurse, she knew her cardiology and I would often refer to her or ask her about a few things that I wasn't clear about.

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Q. In your view she gave good treatment to patients?

11

A. Yes.

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Q. And she had a good relationship with the parents of those patients?

14

A. Yes.

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Q. How did you get along with Miss Nelles when you worked with her?

16

A. I thought well.

17

Q. You enjoyed working with her?

18

A. Yes.

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Q. If I could ask you to turn please to the assignment book. Now, I'm not sure whether it is still there, if not it is in Volume 32C. If you would turn please to Tab 87, I believe that's the 4A assignment book, and if you would further turn to page 179. That is the 4A assignment sheet for



A.6

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Monday, December 22nd and Stephanie Lombardo died
earlier the following morning, is that right?

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A. That's right.

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Q. I direct your attention please
to the long day shift. There is an entry in the first
box in the upper left-hand corner "transfer Lombardo".
Is it your understanding that Stephanie Lombardo was
transferred to Ward 4A on the morning of December 22nd?

9

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A. Some time that day, yes.

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Q. And that entry "transfer

Lombardo" would reflect that transfer onto the ward?

A. Right.

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THE COMMISSIONER: I'm sorry, I
haven't found it yet.

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MR. BROWN: I'm sorry, sir, it is in
the upper left-hand blocks on page 178.

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THE WITNESS: 179?

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MR. BROWN: 178/179.

THE COMMISSIONER: Oh, I see, yes,
all right.

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MR. BROWN: Q. Having established then
that from the assignment book it appears that
Stephanie Lombardo arrived on the floor on the Monday
of December 22nd, would you please review the
personnel on duty on the long day shift and would you



A.7

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agree with me that from the assignment book it appears
Miss Nelles was not assigned to work on Ward 4A that
day?

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A. That's correct.

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Q And if I direct your attention
to the lower part of page 179 which shows the
personnel working on the long night shift on December
22nd you would agree with me that Miss Nelles does
not appear to be assigned to work that night?

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A. That's right.

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Q I believe your testimony was
yesterday on the evening of December 22nd you did not
see Miss Nelles anywhere on the cardiac floor?

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A. That's right.

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MR. BROWN: Okay. Thank you, those
are all the questions I have.

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THE COMMISSIONER: Yes, all right,
thank you. Mr. Strathy?

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CROSS-EXAMINATION BY MR. STRATHY:

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Q Ms. Bucci, my name is Strathy,
I represent Phyllis Trayner. You testified yesterday
that some time after the death of Baby Lombardo you
were told that her shunt had occluded or in effect
clotted off, as I understand the expression?

A. That's right.



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Q And although you weren't sure who told you that would I be correct in assuming that it was some person superior to you in the Hospital pyramid, or do you recall?

A It might have been one of my peers.

Q It might just have been a matter of one of the other nurses coming up to you and saying we have now heard that Stephanie's shunt occluded?

A That's right.

THE COMMISSIONER: Excuse me, did they state it as a fact that it had or was it merely a suspicion?

THE WITNESS: I can't be sure.

THE COMMISSIONER: Because notwithstanding the statements in every newspaper I read we have never called any doctors, of the 200 that we did call, none of them ever gave any evidence that the shunt had occluded. They suspected it, isn't that right?

MR. STRATHY: I think yes, Mr. Commissioner. I think it is accurate to say that without a post mortem examination no one could say for sure whether the shunt --



A.9

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THE COMMISSIONER: That was what they expected. I am just wondering if anybody had ever told you that it had?

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THE WITNESS: As I say, I can't be sure that they said definitely it had occluded.

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THE COMMISSIONER: Yes.

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MR. STRATHY: Well, Mr. Commissioner, I brought out this volume in case it became necessary, Volume 15, page 2559. Ms. Bucci, if you can keep one ear on what I am about to say.

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Dr. Rowe, Mr. Commissioner, said that:

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But strictly speaking of course, without the autopsy, it would not be possible to show that in fact that is what happened. I think that all the other doctors who testified, at least from the Hospital, suggested that it was their conclusion that in all likelihood --

THE COMMISSIONER: I don't want to get into an argument, but the obvious difficulty is that could be an answer. The other answer could be a massive overdose of digoxin.

MR. STRATHY: Quite so.

THE COMMISSIONER: So I mean the other doctors reached that conclusion without considering the alternative. So the only way we could tell would be if someone had actually examined the body.

MR. STRATHY: Yes, the only way to be absolutely certain, yes.

Q. But in the context of my question to Ms. Bucci, would it be fair to say Ma'am that the explanation that was given to you was that the medical opinion at the time was that the shunt had occluded.

A. Yes.

Q. And that it wasn't put to you in terms of a possibility, it was put in terms of



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an explanation by the medical people?

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A. That's right.

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Q. And I take it from the fact

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that you were relieved by that explanation is, that

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your understanding was that shunt occlusion would

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account for the child dying in the very manner in

8

which she did?

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A. Yes.

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Q. And it would also account for

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her in effect dying in a way that was both sudden and
unexpected?

12

A. That's right.

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Q. So once you heard that

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explanation you were personally satisfied that there

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was not any error or misjudgment on your part that

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may have contributed to the death of the child, or

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may have caused you to overlook a decline in her

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condition?

A. That's right.

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Q. Prior to that time, that is

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December of 1980, had you been familiar with other

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babies who had had a form of shunt operation?

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A. I don't remember any.

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Q. Had you had other babies in

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your care who required Heparin infusions?

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A. Again I can't recall.

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Q. Well in this particular case, as I understand it, the Heparin is given in effect to keep the blood thin and prevent clotting?

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A. That's true.

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Q. And you have reviewed the medical record of Stephanie Lombardo in part of your evidence, did you review it before coming here today to give evidence?

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A. Yes.

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Q. And I think you will agree with me that the medical record discloses that this child received Heparin when she was in the ICU?

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A. Yes.

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Q. And that Heparin therapy obviously was to continue while she was on 4A?

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Q. And as I understand it in the chart, you have already been referred to page 90 of her chart; do you have the chart nearby? Exhibit 78. If you could turn to page 90, you have already been referred to the doctor's order with respect to Heparin. At the top of page 90, item no. 3, is that the order of Dr. Lichtman with respect to Heparin on 4A?

A. Yes, it is.



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Q. And as I understand it, as the nurse in charge of the patient, it was your responsibility to look after the administration of that Heparin?

A. Yes.

Q. One thing I wasn't clear about; I did understand that the Heparin had to be changed, I think you said yesterday every 8 hours?

A. I wasn't sure about the time but it did have to be changed at a certain hour.

Q Is it possible, let me put to you my information is that the Heparin was to be changed every 6 hours, is that possible?

A. That could be possible, yes.

Q. In any event the Heparin was to be changed by you at least once during the shift?

A. Yes.

Q. And possibly if it was every 6 hours, possibly twice?

A. That's right.

Q. Is that because Heparin in effect goes stale, or needs to be rejuvenated every 6 hours, or every 8 hours, or do you know?

A. I don't know.

Q. Now as I understand your evidence,



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both yesterday and at the preliminary enquiry, you really have no recall at all of giving Heparin to that child on that particular shift?

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A. That's correct, other than the fact that I was in the medication room with the chart.

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Q. Okay, but to be fair, and I think it is important that you not try to please anybody here, not even the Commissioner. I don't think you do any help to anybody if you guess at an answer, or speculate at an answer. To be fair you are not even really sure whether you were in the medication room with the chart that night?

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A. Yes.

Q. And even if you were --

THE COMMISSIONER: That is certainly pleasing to somebody but it doesn't please me because I don't know what it means. It means you are not sure whether you were; or you are sure that you were, which? What I am asking you now, were you in that medication room with a chart, and Mr. Strathy is asking you if you are sure.

A. Yes, I was in there with the chart.

Q. Yes, all right. You are sure that you were in the medication room with the chart?



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A. Right.

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Q. And are you sure you were in the medication room with the chart at the time a drug was drawn up?

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A. Yes.

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Q. What you are not sure about is whether the drug that was drawn up when you were in there with the chart was Heparin?

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A. That's right.

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Q. It might have been something else?

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A. That's right.

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Q. And there were in all likelihood other medications that you were drawing up that night?

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A. Yes.

16

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Q. And although you checked some medications with Mrs. Trayner, you can't say whether it was Heparin that you checked?

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A. That's right.

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Q. It might well have been digoxin that you checked with her?

21

A. That's right.

22

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Q. And in fact in all probability you were giving digoxin to one or more of your patients that night?

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B6



B7

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A. Yes.

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Q. And if you did give digoxin to

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one of your patients that night, or more of your

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patients, that was something you would have to check

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with Mrs. Trayner?

7

A. Yes.

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Q. Well in your evidence you

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referred to anticoagulant flow sheet which has been

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marked as Exhibit 406, and I gather that the hospital

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is unable to locate an actual flow sheet for this

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child Lombardo. Are you sure that it is that type

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of sheet that was used on 4A and 4B at the time in

14

question?

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A. I am not familiar with this one.

16

MS. CRONK: She said it was not.

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Q. You are not familiar with that?

18

A. No.

19

Q. Let me ask you, are you certain

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that there was a type of flow sheet used for

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anticoagulants?

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A. Yes.

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Q. On 4A and 4B?

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A. Yes.

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Q. Was it a printed form, or was it

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something that was just drawn up freehand by the

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nurses?

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A. No, it was a printed form.

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Q. So there was some form that

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should show administration of the anticoagulant to
baby Lombardo that night?

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A. Yes.

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Q. And that form, whatever it was,

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should have been included with the chart?

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A. Yes.

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Q. The thing that troubles me

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slightly is that given that you don't have any

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specific recall of giving the Heparin to the child,

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and given that we don't have the form, which should

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apparently be signed by you, we really don't have any

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way of confirming independently that you did give

that administration?

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A. I did chart in my progress notes

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that Heparin was infusing.

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Q. Yes, I know that, and that is

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at page 41 of the chart.

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A. Yes.

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Q. Which says:

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"1900 - 0330 hrs."

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You say:

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"Heparin infusing well."

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But apart from that there should actually

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be an entry in the chart on the anticoagulant sheet
showing you did in fact administer Heparin?

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A. That's right.

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Q. And we don't know looking at
this "Heparin infusing well", whether we are talking
about the Heparin that may already have been in the
syringe when you came on shift, is that so?

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A. Yes.

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Q. So it does trouble - it troubles
me a little, I don't know if it troubles you a little,
that we don't see your independent entry showing you
actually administered the drug, does that trouble you?

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A. It troubles me that the flow
sheets, or the document is not in the chart.

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Q. Can you think of any reason why
it is not in the chart?

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EMT/dg

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Q. You mentioned yesterday that the drugs in the medication room were listed alphabetically, and I was pleased to hear you say that because I had been trying to suggest for some time now that they were listed alphabetically and I think perhaps one or two other people agreed with me. But it is your clear recollection they were listed alphabetically in the medication room, is it?

A. Yes.

THE COMMISSIONER: Would they be listed according to their generic name or according to the trade name?

A. I don't remember what they did.

MR. STRATHY: Q. Let's try and probe your memory for a moment and see if you can help us. As I recall from seeing the room itself there are a number shelves, typical shelves. They stretch across the top and they are a number of shelves high. Is that right?

A. That is correct.

Q. Let me ask you this: for example, do you recall that it went digoxin, epinephrine or did it go adrenalin, digoxin?

A. I think adrenalin was first.



EMT/dg
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Q. Okay. Adrenalin first and then was it listed under digoxin which is its chemical name and lanoxin I think which is its trade name. Was it digoxin?

A. I can't help you.

MR. OLAH: Mr. Commissioner, just before my friend goes much further, as I recall the medication set-up there are open shelves and then there is a cabinet with a door on it so there are two separate areas which medication was kept. And then of course locked medication was kept in a third separate area.

THE COMMISSIONER: Well, whatever the system is now was probably the system then so perhaps we could just simply ask --

MR. STRATHY: Well, I'm not sure --

THE COMMISSIONER: Through Mr. Roland we can ask Miss Thompson if she will find out for us on this.

MR. STRATHY: I doubt very much, if the system with respect, is the same today as it was.

THE COMMISSIONER: No, but at least if it is alphabetical or not.

MS. CRONK: Before we add to the burden,



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already immense, of Miss Thompson from day-to-day
sir, I recognize Mr. Strathy is certainly entitled
to probe it as he wishes with this witness.

THE COMMISSIONER: Yes, no question.

MS. CRONK: But you have had evidence on
this by Mary Costello, sir.

THE COMMISSIONER: And what did she
say?

MS. CRONK: She said the drugs were
at the time stored alphabetically, and she also
gave evidence as to whether under digoxin or lanoxin,
and her evidence was as I recall it, it was digoxin.

THE COMMISSIONER: Yes.

MS. CRONK: And there was discussion
about other drugs at the same time. I think we
went through a whole myriad.

MR. STRATHY: Okay.

THE COMMISSIONER: Yes. All right.

MR. STRATHY: Q. Let me ask you this:
I think it was suggested to you yesterday that the
heparin was on a different shelf from the digoxin.
Do you recall that as a fact that it was on a
different shelf than the digoxin?

A. No.

Q. I want to show you some vials



EMT/dg
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that have been marked as part of Exhibit 224. This vial I am showing you is marked "hepalien lok" Would you look at that?

Now is that the sort of vial that was used for the heparin?

A. No.

Q. Okay, I wondered about that because it says it is not for anti-coagulant therapy on it?

A. Hm-mm.

Q. Do you know what that vial was used for?

A. I had never seen that vial before.

Q. OK. And then there is a vial entitled "paediatric lanoxin". Do you recognize that as a type of vial of paediatric digoxin in use on the ward when you were there?

A. It has changed a little.

Q. And is it a similar sort of vial?

A. Ampule, yes.

Q. Ampule. And the adrenalin that was in use for patients such as Lombardo, was it similar to the vial of digoxin that we see.

A. Yes.



EMT/dg
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Q. Was it a clear vial.

A. Yes.

Q. The lettering on the digoxin vial is green. Do you recall what colour the lettering on the adrenalin vial was?

A. It was black.

Q. Black? Okay. Same sort of size print?

A. Yes.

Q. Do you remember any band around the top?

A. No.

Q. Now just while we are at page 41 of the chart, you have a note there, after the start of the note from 1900 hours to 0330 hours, "Dusky when upset. Became restless after second feeding. However settled well".

Now the thing I was a little uncertain about is whether that "Became restless after second feeding. However settled well" refers to the 3:00 o'clock feed or midnight feed, do you know?

A. To try to make sense of this I think it is the midnight feed.

Q. Midnight feed?

A. Yes.



EMT/dg
C6

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Q. Okay. Is there any particular reason why you say that?

A. If I am listing them numerically, first, second and third feed.

Q. Okay. But you don't make any reference to the third feed on the chart at least?

A. No.

Q. Do I take it that in any event after you fed the child at 3:00 o'clock it took you a little while to put the child down, to tidy up and so forth?

A. After which feed, I'm sorry.

Q. The 3:00 o'clock.

A. It took a short time.

Q. And your best estimate is that after doing that you went back to the nursing station and it was a matter of only five or ten minutes before Phyllis Trayner called you?

A. That is right.

Q. Now Phyllis Trayner that evening was the team leader?

A. Yes.

Q. And it was part of her job to make regular rounds of the children in the ward?

A. Yes.



EMT/dg
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Q. And is it your recollection that she did in fact make rounds throughout that night?

A. I can't remember.

Q. Well, in any event I gather from your evidence that although you don't know what she was doing at the time that she made the observations of the Lombardo child, it is entirely possible that she was on her rounds at the time?

A. Yes.

Q. Or on the other hand I suppose it is entirely possible that she was simply passing by the room and noticed the child in distress?

A. Yes.

Q. You talked about the child being in an isolette, and Miss Cronk will probably tell us there has been evidence about what an isolette is, but just to refresh my memory I recall it is a sort of clear plastic, almost a plastic box type thing in which the child is placed?

A. Yes.

Q. And it is a controlled sort of environment, temperature controlled?

A. Yes.

Q. Also oxygen can be put into it?



EMT/dg
C8

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A. Yes.

3

Q. As I understand it, part of the

4

reason for putting a child in a isolette is not

5

simply to control the child's environment but also

6

to have a better observation of the child?

7

A. Yes.

8

Q. In other words, because it is

9

clear on all sides you can look in, view the baby

10

without disturbing the baby?

11

A. Yes.

12

Q. And rather than being kept

13

bundled up or wrapped up or covered up, children

14

are in effect left in there in their diapers?

15

A. Yes.

16

Q. So you can make pretty easy

17

and rapid observations of at least the exterior

18

appearance of the child?

19

A. Yes.

20

Q. And would I be correct in

21

understanding when you talk about the child being

22

in distress, you mentioned the child's breathing,

23

and that one might simply be able to notice

24

from the chest movements the child was in distress?

25

A. Yes.

Q. Would it be fair to say too that



EMT/dg
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you might simply notice from the child moving about,
the nature of the child's physical movements, the
arms and legs, that the child was in distress?

A. There are - there is a possibility
yes. If the child was crying it is hard to
distinguish the two.

Q. But to somebody, let us say,
walking by the door and seeing the child in the
isolette might simply be able to tell not just
simply from the breathing of the child but the
nature of the child's movements that there was
something amiss.

A. As I say, on different occasions,
yes.

Q. Is the isolette lit itself?
Is there some type of interior lighting?

A. No.

Q. But there would be lights
around it that would illuminate the child?

A. Dim lights that night.

Q. I thought you suggested to
Mr. Shanahan or perhaps to Miss Cronk that there
would be enough lighting in the room that night
before the arrest so that you might be able to
detect from the doorway changes in the child's



EMT/dg
C10

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colour, for example.

A. I can't be sure, but I think possibly I might say different shades of colour, yes.

Q. Then you testified that after you went into the room with Mrs. Trayner you took the child's apex?

A. Yes.

Q. And that was at her suggestion?

A. Yes.

Q. And taking the apex - I'm not sure whether you said it yesterday or at the preliminary, but in any event you would agree with me that that is fairly standard procedure. Just about the first thing you do when you find a child may be in trouble?

A. Yes.

Q. You would agree that it is good nursing practice?

A. Yes.

Q. Now do you see the plan of 4A and 4B just over to your right?

A. Yes.

Q. Do you mind just walking over to that, please, and simply pointing with your finger



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Bucci cr.ex.
(Strathy)

2286

EMT/dg
C11

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to where the child's isolette was?

3

A. It was under this window

4

(indicating).

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18

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A. It is under this window right here.

4

5

Q. You are pointing to the - it looks to me like the middle of the three windows?

6

A. Yes.

7

Q. So it was right under that?

8

A. Yes.

9

Q. In room 418?

10

A. Right.

11

Q. And when you were sitting with

12

your friends in the nursing station where were you positioned, can you point to that?

13

A. The table was in the centre, I was on this side.

14

15

Q. You are pointing to just the

16

top back of the nursing station on the right hand side?

17

A. Right.

18

THE COMMISSIONER: Is it the back or were you pointing - I thought it was sort of --

20

THE WITNESS: It was towards the back.

21

THE COMMISSIONER: Yes, it is about two-thirds of the way back, would you say from the entrance?

22

23

THE WITNESS: Yes.

24

25

/BM/LN

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MR. STRATHY: Two-thirds of the way back in the nursing station, just above where we see the words "nursing station" on the plan.

A. Okay.

Q. And you were at a table there with your friends?

A. Yes.

Q. All right, thank you. The room that the child was in was 418?

A. Yes.

Q. As I understood your evidence yesterday, after you had gone into the room with baby Lombardo with Phyllis and were in the room with Phyllis and the others and the baby, your friends who had been with you in the nursing station left the nursing station?

A. Yes.

Q. And they waved to you through the window that separates the nursing station from 418?

A. One friend, yes.

Q. One friend?

A. Yes.

Q. So obviously she was able to see you and you were able to see her?



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2

A. Yes.

3

Q. And it is your recollection that

4

the - is it a curtain or a blind on the window?

5

A. Shades.

6

Q. Shades?

7

A. Window shades, yes, like these.

8

Q. So, venetian blinds type of

thing?

9

A. Yes.

10

Q. And it is your recollection that

11

the venetian blinds then were opened at that time?

12

A. Yes.

13

Q. And were they, like the windows

in this room, were they down but open?

14

A. They were vertical or horizontal

15

like these.

16

Q. They were horizontal but had

17

the blind been lowered down and then opened up?

18

A. As I can recall they don't open

19

up and down.

20

Q. They don't go up and down?

21

A. Right.

22

Q. So, they were down but opened?

23

A. Right.

24

Q. I take it that that's the way

25

25



1

2

had been during the time that you had been in the
nursing station with your friends?

4

A. I don't remember anyone opening
or closing them.

5

6

Q. There wouldn't be any particular
reason after the child was discovered to open the
blinds, would there?

7

8

A. No.

9

10

Q. So, is it a fair assumption
that they had been opened while you were in the
nursing station with your friends?

11

12

A. Yes.

13

14

Q. And you testified that although
you could not see the baby's isolette from the nursing
station because it was under the window level?

15

16

A. Right.

17

18

Q. So you wouldn't actually be
able to physically observe the baby from the nursing
station?

19

A. That's right.

20

21

22

23

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Q. Would it be fair to say that
given the fact that there was some lighting in
room 418 that night that had someone gone up to the
child's bedside and had you been looking through the
window in the nursing station, from the nursing



1

2

station, you would have seen that person?

3

A. If one was looking?

4

Q. Yes.

5

A. Yes.

6

Q. And I take it that whether or

7

not you were looking while you were with your friends
in the nursing station you didn't while you were

8

with your friends in the nursing station see anyone

9

through that window?

10

A. Yes.

11

Q. Do you recall whether you did

12

look through that window or not?

13

A. No, I don't remember.

14

Q. I don't know whether that plan -

15

there is a scale on that plan, I think there is, but
how far would it have been from your table where

16

you were sitting to the window separating the nursing

17

station from 418?

18

A. 10 feet.

19

Q. Thank you. Now, you told Mr.

20

Shanahan, who was the last questioner yesterday,

21

that to your recollection Phyllis Trayner remained

22

calm during the cardiac arrest?

23

A. Yes.

24

Q. And I take it that's the sort

25

D5



D6 1
2 of thing you would hope that any team leader or
3 nurse did during a cardiac arrest?

4 A. Yes.

5 Q. You have to be calm to carry out
6 your responsibilities during the arrest?

7 A. Yes.

8 Q. In your experience as a nurse,
9 and perhaps even your own experience that night, after
10 the arrest is over when all your work is done and I
11 suppose particularly if the patient does not live,
12 is it common that a nurse will have a cry, be upset?

13 A. Yes.

14 Q. You may keep yourself under
15 control while you are carrying out your duties, but
16 when all is said and done you let yourself go a little
17 bit?

18 A. Yes.

19 Q. Do you recall what you did that
20 night?

21 A. I was upset, yes.

22 Q. Do you think after the arrest
23 when the child had died you cried?

24 A. I recall crying, yes.

25 Q. And then I gather you personally
had some concerns about your own abilities or about



D7

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your own actions after that wondering if something
you did or failed to do might have contributed to
the death?

4

5

A. Yes.

6

7

Q. But once you got an explanation
that you considered acceptable that was convincing
for you?

8

9

A. Yes.

10

Q. Now, one last thing. You mentioned
I think that a Miss Palmer spoke to the parents --

11

THE COMMISSIONER: Powers?

12

MR. STRATHY: Powers, excuse me, Karen
Powers.

13

14

A. Yes.

15

16

Q. Sorry. And as far as I could
understand there was no particular rhyme nor reason
as to why one person rather than another would speak
to the parents?

17

18

A. That's right.

19

20

Q. Was it sort of a collective
decision amongst the nurses as to who might be the
best person in the circumstances to go see the
parents?

21

22

A. No.

23

24

Q. Do you know how the decision

25



1
2 was made, did it just happen?

3 A. It just happened, yes.

4 Q. But obviously it is considered
5 important that some member of the nursing staff
6 talk to the parents?

7 A. Oh, yes.

8 Q. And in your experience that was
9 always done I take it?

10 A. Yes.

11 Q. But as between yourself, Phyllis,
12 Miss Powers, you can't think of any particular reason
13 why Miss Powers rather than the others would have done
14 it?

15 A. That's right.

16 MR. STRATHY: Thank you.

17 THE COMMISSIONER: Yes, thank you, Mr.
18 Strathy. Mr. Hunt?

19 CROSS-EXAMINATION BY MR. HUNT:

20 Q. Ms. Bucci, my name is Hunt and
21 I represent the Attorney General and the Crown Attorney
22 and the Coroner.

23 Now, as I understand it, the scene on
24 the night that baby Lombardo died was that of a ward
25 where, because of the Christmas holidays, Christmas
season, the population was significantly reduced?



D9

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2

A. Yes.

3

Q. And as well the staff was reduced?

4

A. Yes.

5

Q. And at the time that you came on

6

you were met with a baby, Baby Lomardo, that you

7

didn't feel required any special attention at night?

8

A. Yes.

9

Q. It was a baby was recovering

well after surgery?

10

A. Yes.

11

Q. Feeding well?

12

A. Yes.

13

Q. Vital signs were well?

14

A. Yes.

15

Q. Nothing about her progress

during the night shift up until the point when Nurse

16

Trayner called you that was alarming in any way?

17

A. That's right.

18

Q. When the baby died, I take it

19

that you were not just upset, you were shocked?

20

A. Yes.

21

Q. And that's because this death

22

in such a dramatic way really shattered what, up

23

until that point, had been a relatively peaceful and

24

really uneventful night on the ward?

25



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2

A. Yes.

3

Q. Particularly with the baby

4

that as far as you were concerned the last thing you
5 expected was to see that type of reversal in such
6 a short period of time?

6

A. Yes.

7

Q. When the police came and spoke

8

to you in February of 1982, I think it was about

9

Baby Lombardo, you certainly remembered events

10

surrounding her demise that night?

11

A. Yes.

12

Q. You didn't have any trouble

13

with that?

14

A. Yes.

15

Q. Would I be fair to say that

16

since you have been a nurse in 1978, the death of
16 Baby Lombardo, in the circumstances that we have

17

discussed here, is one of the most dramatic reversals
18 in a patient's progress that you have seen?

19

A. In a different manner.

20

Q. Well, let's deal first --

21

Do you agree that the death of Baby Lombardo ranks
21 in your memory of your experience as one of the

22

most dramatic reversals in a patient that you have

23

seen?

24

25

D10



D11

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A. Yes, but I have had only a few.

3

Q. That may be and we will deal

4

with that. But you do find that there is something

5

about the way Baby Lombardo was progressing and then

6

suddenly died that makes it certainly a significant

7

recollection for you?

8

A. Yes.

9

Q. Is it one of the most upsetting

10

incidents that you have had to experience in your

11

years as a nurse?

A. No, I have had others.

12

Q. I didn't say that, but I said

13

rank up there with the others as one of the most

14

upsetting?

A. Yes.

15

Q. I suggest to you that it is

16

something that you are going to remember for quite

17

some time?

A. Yes.

18

Q. Do you know what Phyllis Trayner's

19

recollection of baby Lombardo is?

20

A. As far as I know she has none.

21

Q. Yes, absolutely none. Does

22

that surprise you a little bit?

23

A. A little, yes.

24

25



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Q. Does it surprise you because of really the background to the death of this baby that we have looked at?

MR. STRATHY: Mr. Commissioner, I don't know that it helps us to have this witness' comments on the evidence of another witness in the particular circumstances. I don't think that's job for the witness.

THE COMMISSIONER: Well, the fact that she is surprised that Phyllis Trayner does not remember it, is surely something that she can say because it is based upon her own memory, her own recollection of it.

MR. STRATHY: Well, it may be something that she can say, Mr. Hunt asks for her opinion and she can give it but whether that assists the commission is another matter.

THE COMMISSIONER: That surely is a matter for argument. The fact that she does remember and is surprised that someone doesn't remember may be relevant to the cause of death, that's all.

MR. STRATHY: Well, with all respect, it seems to me there are certain questions that are for the commissioner and certain questions that are for the witness and I thought the proper questions



1
2 to ask the witness were questions that concerned how
3 and by what means the child met its death.

4 THE COMMISSIONER: Yes.

5 MR. STRATHY: And not ask the witness
6 to compare her evidence with someone else's evidence,
7 or her recollection with someone else's recollection.

8 THE COMMISSIONER: No, I think it is a
9 legitimate question and I will allow it.

10 MR. HUNT: Thank you.

11 Q. I take it, Ma'am, that you're
12 surprise is based at least on part of the fact that
13 the events as we have described them leading up to
14 the death of baby Lombardo are such a contrast to
15 what happened in the short period of time after you
16 left the baby and the baby went into a reversal and
17 couldn't be revived?

18 A. I should say yes.

19 Q. Now your reaction to the baby's
20 death in those circumstances, aside from the upset
21 that you experienced, this was one that caused you
22 to really wonder about your own abilities, didn't it?

23 A. Yes.

24 Q. Your reaction to the death of
25 this baby under your care in those kinds of
circumstances, at least for a while, shook your own



D14

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2

confidence?

3

A. Yes, it did.

4

Q. In your ability as a nurse didn't

5

it?

6

A. Yes.

7

Q. Your thought was what if anything

did I miss?

8

A. That's right.

9

Q. Did you wonder how someone else,

10

Phyllis Trayner, was able to see something that you

11

yourself must have missed?

12

A. I didn't wonder in that way.

13

Q. How did you wonder?

14

A. No, I just - she found the baby

15

in distress and I didn't see the baby, I just was
alarmed at that.

16

Q. But you thought in some way it

17

reflected on your own abilities, didn't you?

18

A. Only because I had left the baby.

19

I thought the baby was fine and in a short time it

20

deteriorated so quickly, yes.

21

Q. I don't disagree that would be a

22

natural reaction, Ma'am, that the baby being under

23

your care all night all, you had left the baby and

24

within a very short period of time the baby goes into

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D15

a tailspin and dies, your confidence in the care you
had given and in your ability to give proper care
was at least temporarily thrown into doubt in your
mind?

A. Yes.

— — — — —



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Q. Did you wonder whether maybe some of the others on the ward are going to be looking at you that way too?

A. No.

Q. Maybe some of your colleagues are going to wonder about your ability to properly care for a child?

A. No.

Q. You were only concerned in your own mind then?

A. I was criticizing myself.

Q. I am not suggesting others were criticizing you.

A. No, that's my explanation.

Q. I am just saying part of the shaking of your confidence involved as well the thought about, what are the others going to think of my abilities to look after a child with something like this happening?

A. I never thought of it that way.

THE COMMISSIONER: I am sorry, you never thought of it --

THE WITNESS: I never thought of it to be that way, that others would question my ability.

MR. HUNT: Q. Now you have also talked



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about the window in the ward with Mr. Strathy, and it has been some time since I went to look at that window, but it is my recollection it is two panes of glass with a blind as you say, like a Venetian blind, between them?

A. That's right.

Q. And a little device that you can turn on the outside that closes the blind or opens the blind?

A. That's right.

Q. And these panes of glass have wires running through them up and down I believe?

A. That I don't remember.

Q. All right. It is my recollection that the lighting in the room itself, that is the ward, is different than the lighting at the nurses station, or at least it may be made to be dimmer at certain times than the lighting outside?

A. Yes.

Q. When that is true, so that it is dimmer in the room and brighter outside, in order to really see anything effectively do you not have to go right up to the window and look through these Venetian blinds and the wires running through in order to really see anything clearly inside?



E.3

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A. From the nursing station, yes.

3

Q. And that is particularly so

4

when it is dim inside the room as opposed to being
bright outside at the nursing station?

5

A. Yes.

6

Q. I take it nighttime is when the
lights inside the room are usually dim?

7

8

A. That's right.

9

Q. And when you were with your

10

friend at night at the nursing station, would I be
correct that you were seated at the table?

11

A. Yes.

12

Q. So in effect you would be lower
than you would be if you were standing up walking
around and right over looking in the window?

13

14

15

A. Yes.

16

Q. And to that extent your ability
to see inside the room would certainly be restricted?

17

18

A. Yes.

19

Q. Severely restricted?

20

A. Yes.

21

MR. HUNT: Thank you. Those are the
questions I have.

22

THE COMMISSIONER: Mr. Young?

23

MR. YOUNG: Mr. Commissioner, I have

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no questions for this witness.

THE COMMISSIONER: Mr. Roland?

MR. ROLAND: Yes, I have just a couple of questions.

CROSS-EXAMINATION BY MR. ROLAND:

Q. My name is Ian Roland and I act for the Hospital. I am intrigued about the form, the anticoagulant form that you say that you had, or you remembered the night of Baby Lombardo's death. Had you seen that form before that night, or had use of it before that night?

A. I don't remember.

Q. Do you recall the form after, any time after that baby?

A. No.

Q. So that was really, as far as you can recall, the only time you saw that form having to do with Baby Lombardo?

A. I didn't say I saw it. The normal procedure would be to sign on one of these forms.

Q. Is this a form that you recall from other hospitals that you had worked at?

A. I have to admit I might be imagining the one that they use at Toronto General



E.5

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but I do recall Sick Kids having one of these forms.

3

Q. You do. Because the problem

4

is we have looked for a form and it is not a stock

5

form on the ward, it is not a form that the Hospital

6

is aware of.

7

A. Well then I have to say I

8

am probably imagining the one I have used prior to

9

being at Sick Kids.

10

Q. You think you may be thinking

11

of a form that you recall from some other hospital

12

that you worked at?

13

A. Yes. Then I have to ask where

14

we would chart if it is not listed on the medication
record?

15

Q. Well we have looked through,

16

and there are at least two other infants that you

17

had, at least at the critical times that you were not

18

in the care of, but who were on heparin therapy,

19

Jesse Belanger and Antonio Adamo, and on both of

20

their charts there are orders for heparin therapy

21

and they both had shunts and there was no form in

22

either of those charts either.

23

THE COMMISSIONER: This is is there

24

a record --

25

MR. ROLAND: It is a record --



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2 THE COMMISSIONER: It is a record of
3 actually having given the medication?

4 MR. ROLAND: Yes. It is ordered and
5 it is recorded and it is recorded in the progress notes
6 and so on, heparin infusing and so on, but there are
7 no forms in that, and that is why I am asking about
8 this one.

9 MS. MCINTYRE: Is it on the medication
10 and treatment record for those other charts?

11 MR. ROLAND: I think it is on the
12 nursing progress'notes, it is not on the certification
13 and treatment records on those charts either. The
14 understanding that we have that it was the practice
15 of the Hospital at the time is that it didn't go on
16 the medication and treatment records, it was simply
17 something ordered and it was recorded from time to
18 time in the progress notes.

19 THE WITNESS: That is not good practice
20 then I have to say.

21 MR. ROLAND: Q And the reason is
22 because it is not given - the reason it would not be
23 on - as I understand it and from your evidence, it
24 would not be on the regular medication record is
25 because it is not given at a regular time, it is
replaced, or additional heparin is given as needed?



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A. Okay, I believe you, but it is a medication and all medications should be charted.

Q. Yes. In any event you didn't - I gather what you tell us today is that you are not certain that there was actually such a form at all at the Hospital?

A. Right.

Q. You recall some sort of form but it may be you are thinking about some other hospital?

A. Yes.

MR. ROLAND: Thank you.

THE COMMISSIONER: Mr. Ortved, you have just come in.

MR. ORTVED: I have no questions.

THE COMMISSIONER: No questions. Mr. Olah?

MR. OLAH: No questions, Mr. Commissioner.

THE COMMISSIONER: Mr. Labow?

MR. ROLAND: Mr. Commissioner, perhaps - Miss Thomson has pointed one thing out to me.

THE COMMISSIONER: Yes.

MR. ROLAND: Just to clear up this.

Q. The way in which I understand it, Ms. Bucci, you check the heparin therapy is by

(2)



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protamine check, it is done in the laboratory of
the Hospital?

3

4

A. Yes.

5

Q. And there are records of that
in the chart.

6

A. That refreshes my memory, yes.

7

Q. That is something that is done
on a regular basis when a baby is on heparin therapy.

8

9

A. Yes.

10

Q. To determine if it is having
the proper effect it is supposed to be having.

11

12

A. Right.

13

Q. And we found those records in
the charts of Belanger and Adamo and Lombardo and you
would expect that in a chart?

14

15

A. Right.

16

MR. ROLAND: Thank you.

17

THE COMMISSIONER: Mr. Labow?

18

CROSS-EXAMINATION BY MR. LABOW:

19

Q. Mrs. Bucci, my name is Stephen
Labow and I represent a number of children who died
on the ward.

20

21

Mr. Commissioner, before I begin,

22

there was some question when I examined Mrs. Trayner
about the page in Philip Turner's medical record that

23

24

25



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Susan Nelles had not identified.

3

THE COMMISSIONER: Yes.

4

MR. LABOW: And said it wasn't hers, and
it is at Volume 127, page 8838.

5

6

THE COMMISSIONER: Yes.

7

MR. LABOW: I did ask her specifically --

8

THE COMMISSIONER: And she said --

9

MR. LABOW: She said she did not write
it.

10

11

THE COMMISSIONER: Yes. I still find
it a little odd but perhaps that is the document that
really doesn't belong in the chart at all.

12

13

MR. LABOW: That may be it, I am
trying to identify it for that reason.

14

15

THE COMMISSIONER: Yes.

16

MR. LABOW: Q. Mrs. Bucci, you
indicated to Ms. McIntyre that you frequently reported
to the Trayner team because you frequently worked
the long day shift when the Trayner team was on at
night?

17

18

19

20

A. That's right.

21

22

23

Q. And that you were made aware
of deaths that occurred during the night some time
when you came back on shift the next day, or a number
of days later?

24

25



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A. Yes.

3

Q. Now you also told Ms. McIntyre

4

that you did realize that deaths were occurring on the

5

night shift with the Trayner team, and when she asked

6

you when, you said it was when Mrs. Trayner was

7

married and came back from her vacation and there

8

was an arrest the night she came back?

9

A. Yes.

10

Q. That is at page 2216-2217 of

11

yesterday's transcript. Now my understanding is that

12

Mrs. Trayner was off for most of the month of

13

September. We have heard that she came back some

14

time at the end of September and the arrest in question

was the arrest of Brian Gage?

15

A. Yes.

16

Q. Now that arrest was - he died

17

on the 25th of September?

18

A. All right.

19

Q. Prior to that death the only -

20

the next death back in time was at the very beginning

21

of the month when Laurette Heyworth died, and the

22

suspicious death before that one, because that is

23

not one of the suspicious deaths of this Commission

24

according to the Atlanta Report, was Baby Velasquez

25

on the 24th of August?



E.11

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2

A. Right.

3

Q. So there had not been a death

4

on the ward for almost a month?

5

A. All right.

6

Q. Although there had been a large

number of deaths in July and August?

7

A. Yes.

8

Q. But you realized after there

9

not being any deaths in September, aside from the one,

10

that when Mrs. Trayner came back there was another

11

death and that sort of brought to you that there had

12

been a lot of deaths when her team was on?

13

A. Yes.

14

Q. So it was that one death at the

15

end of September after not having any deaths for

16

almost four weeks that made you realize that there

were a lot of deaths when her team was on?

17

A. We thought it was awfully

18

coincidental.

19

Q. You thought it was awfully

coincidental, did you discuss that with anybody?

20

A. My nursing team.

21

Q. Just your team?

22

A. As far as I can recall.

23

Q. Did you feel that you should

24

25



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2

go any further with that?

3

A. No.

4

Q. Well it obviously struck you

5

as interesting that after being away for that long

6

and not having many deaths on the ward there was that

7

one death the day that Mrs. Trayner came back?

8

A. We thought it was odd, but as

I say coincidental.

9

Q. You thought it was no more

10

than coincidence at the time that you discussed it?

11

A. That's right.

12

MR. LABOW: Mr. Registrar, could you

13

show the witness the Hospital records for Matthew Lutes
and Real Gosselin, please?

14

Q. According to the exhibit that

15

your counsel filed on your behalf, that is Exhibit 407,

16

you were on the night, the day before, the long day

17

shift before Matthew Lutes died, and you had the

18

care of Matthew Lutes and two others?

19

A. Yes.

20

Q. You had actually cared for

21

Matthew Lutes for three days prior to his death,

22

according to the Hospital record and your progress

23

notes begin at page 49 of the Hospital record. Now,

24

on page 49 you have a note written for the 14th of

25

November?



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2

A. Yes.

3

Q. Now I assume from what we have

4

heard you wrote that note at the end of the shift?

5

A. Yes.

6

Q. And it was a very short note?

7

A. Yes.

8

Q. So from my understanding of the

POMR recording method there were not too many problems

9

with Matthew Lutes the night, the day of the 14th?

10

A. That's right.

11

Q. Now your note for the 15th is

12

near the top of page 50, and the same thing occurred,

13

it is a relatively short note, and aside from some

14

vomiting and his groin wound there wasn't much to

report about that child?

15

A. That's correct.

16

Q. So can I take it that you were

17

not terribly concerned about this child at that time?

18

A. Yes.

19

THE COMMISSIONER: Yes, you were not
concerned, or yes, you were concerned?

20

THE WITNESS: Yes, I was not concerned.

21

MR. LABOW: Q. Could you turn to page 53.

22

Now your note for the long day shift on the 16th is

23

much longer. Did you become concerned about the

24

health of this child that day, do you recall?

25



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A. I don't recall the baby. I will just go by the notes.

Q. So you don't have any independent recollection?

A. No.

Q. Well, your note seems to indicate that there were some problems, but at the very bottom of your note you indicate that:

"Called dad. Flew in immediately."
Do you know who told you to call the father or if you did it on your own?

A. I don't know.

Q. Is it a normal thing to call the father, to call if there was any specific concern?

A. Not unless requested to do so.

Q. So that would be requested by whom, a doctor or --

A. The doctor would probably do it himself. I would think the mother asked me to. I am just imagining.

Q. You are not sure?

A. No.

Q. Were you surprised that he died on the night of the 16th?

A. I have no recollection. I don't



1

2

know.

3

Q. Okay. Thank you very much.

4

Would you look at Real Gosselin's chart? Now Real Gosselin was only admitted on the 17th of December, early in the morning, and you had the care of that child for the one day shift that he was in the Hospital.

8

Do you recall if you were aware that on admission he had a high digoxin level?

10

A. I don't remember this baby.

11

Q. Could you look at page 44 of the Hospital record? Now you wrote your nursing note at the bottom of that page, and your note begins and says that he was in no distress. It is a little hard to read.

15

A. Yes.

16

Q. But you are saying respirations, and then you say in no distress.

17

18

A. Yes.

19

Q. Although his breathing became increasingly laboured later in the day?

20

A. Yes.

21

Q. Above your note is the note from Dr. Stephen?

22

23

A. Yes.

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Q. And that note indicates that there was a digoxin level of 3.9 in the morning and digoxin had been held and that they were going to try Lasix, and if the child didn't improve, they would discuss the digoxin issue?

A. Yes.

Q. Reading that do you have any recollection whether you knew that was the case?

A. I don't recall this baby.

Q. Do you recall if you had any special instructions --

A. No, I don't remember.

Q. -- for the care of this child?

A. No.

Q. Do you recall if you were surprised to find out that he died that night?

A. I don't remember.

Q. Now you also note on page 45 at the very end of your note that Dr. Stephen gave Lasix at 1945.

A. Yes.

Q. Now your shift ends at 1900; is that correct?

A. Approximately - a little later.

Q. Can I assume that you were a



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little concerned and stayed later?

3

A. 1945, yes.

4

Q. So do you know -- does that
bring back any recollection as to your concerns about
this child that day?

5

6

A. No.

7

8

Q. Now you had the care of the
Lutes child on the 17th of November.

9

A. Yes.

10

11

12

Q. And the Gosselin child on the
18th of December, and between we have heard about
deaths on the 9th and 13th of December. Those were
Babies Onofre and MacDonald.

13

14

15

16

Then at the end of December there
were two more deaths, Baby Lombardo and Baby Belanger.
So in a span of six weeks there had been six deaths on
4A/B.

17

A. All right.

18

19

Q. Do you recall if you or anyone
else had any concern about this new cluster of deaths
on the ward?

20

21

A. I don't recall anything.

22

Q. You don't recall whether you
did or didn't?

23

24

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A. I don't recall whether we did.



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Q. Now was that a large number of deaths in that space of time?

3

4

A. With my experience, yes.

5

Q. Okay. Now you had been concerned when Mrs. Trayner returned at the end of September that there was a death the night she got back and things seemed to cool down a little when suddenly in December, November, December, there was another large number of deaths.

6

7

8

9

10

Did you or your team discuss the increase?

11

12

A. I don't remember.

13

Q. Okay. Now lastly you were the team leader on Ward 4A the day before Kristin Inwood died.

14

15

A. Yes.

16

Q. And Exhibit 407 indicates that you don't have any recollection of this child?

17

18

A. That's right.

19

Q. If the team leader on the other side was particularly concerned about a child, would she normally discuss it with you? It seems that you were the team leader on 4A that day.

20

21

22

A. If she was concerned enough, yes.

23

Q. Now Mrs. Trayner has told us,

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and this is at Volume 138, page 1716, that Mrs. Bracewell, who was the team leader on 4B that day, was very concerned about the child all day, and that when the night shift's came on, she was informed that there was a concern about this child.

Do you recall Mrs. Bracewell discussing this child with you at all that day?

A. I don't remember.

Q. Could she have and you just don't recall?

A. That's right.

Q. Now you had been off at the beginning of March when there was another flurry of deaths on the ward, but you were on when there were a number of deaths in the second week of March.

A. Yes.

Q. And by the time Kristin Inwood died there had been six deaths in seven nights.

A. Yes.

Q. Do you recall if there was any concern at that time for you or your team about this --

A. For myself.

Q. -- increase?

A. For myself, yes.

Q. You were concerned?



1
F7 2 A. Yes.
3 Q. Was it some time after the
4 Inwood death?
5 A. I can't place a time on it.
6 Q. Some time around the middle of
7 March?
8 A. Yes.
9 Q. Before we get to the Miller and
10 Cook deaths?
11 A. Yes.
12 Q. Who did you discuss it with?
13 A. I discussed it at home.
14 Q. You didn't discuss it with anyone
15 on your team?
16 A. I don't recall any discussion.
17 I may have.
18 Q. Did you bring it to the attention
19 of any of the doctors?
20 A. No.
21 Q. Or any of the nursing administra-
22 tion?
23 A. No.
24 Q. But you were concerned?
25 A. Yes.
Q. Why were you concerned?



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A. Too many babies were dying.

3

Q. Did you think there was something
irregular going on?

4

5

A. No. My experience on the ward
was a lot of deaths and that's what I thought it was.

6

7

Q. So you just thought it was
another bunch of deaths?

8

A. Yes.

9

10

Q. But you didn't have any answer
for it?

11

A. No.

12

MR. LABOW: Thank you. I have no
further questions.

13

14

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16

THE COMMISSIONER: Miss McIntyre, do
you want to re-examine now or do you want to wait until
after the break? Or do you not want to re-examine at
all?

17

18

19

MS. MCINTYRE: Well, no, I do have
some questions. Possibly I could wait until after the
break.

20

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THE COMMISSIONER: Yes. All right.

Miss Thomson, did you have something?

No? All right. We will take 20 minutes now then.

--- recess.



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2 --- on resuming.

3 THE COMMISSIONER: Before you start,
4 Miss McIntyre, I am going to ask Mr. Lamek to tell us
5 something about his plans.

6 MR. LAMEK: There have been a number
7 of questions about the scheduling for next week. As
8 you know, following the evidence of Mrs. Bucci, we will
9 be calling Miss Palmer, and Miss Palmer, as I am
10 presently advised, is the last of the witnesses whom
11 Commission Counsel presently intend to call.

12 On Monday we will hear evidence from
13 three parents, from Mrs. Dawson, from Mr. Lombardo and
14 from Mrs. Hines. The evidence of those witnesses
15 will be led by their respective counsel. And inter-
16 views and telephone conversations and conference calls
17 have been arranged for Friday and more will be
18 arranged for the beginning of next week with other
19 physicians and nurses whose presence has been requested
20 as witnesses here. And on the basis of those meetings
21 or conference calls decisions will be made as to
22 whether the evidence of any of those people will be
23 led by Commission Counsel.

24 I will be in a position to be of more
25 help to you at the beginning of the week, sir, and
although obviously not with respect to all of them,



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certainly with respect to those to whom we talk on Friday. At the moment I know of no other individual witness whom I presently intend to call. I can't tell you that's the end of my evidence because it depends on the conversations tomorrow and Monday.

THE COMMISSIONER: Yes. Well, as soon as you do tell us that this is the end of your evidence, I intend to turn to each counsel in turn and to ask whether they intend to call evidence, and if they do and certainly if/^{it}requires a subpoena or any kind of order from me, they will have to justify the evidence that they are going to call. So I would ask counsel to be prepared.

Now obviously you can't be prepared as to the people you are going to call until you know what Mr. Lamek is doing, but you can at least form a preliminary opinion and prepare your argument if you think that you can't persuade Mr. Lamek, then you have to persuade me. Unless of course it is a witness within your control.

Yes, Mr. Olah?

MR. OLAH: Looking a little further down the road, is it your intention that if counsel want to make submissions, and I'm not sure what position I am going to take, that you will take some time off



1
2 in order to allow counsel to prepare for submissions?

3 THE COMMISSIONER: You are talking
4 about argument?

5 MR. OLAH: Yes.

6 THE COMMISSIONER: Oh, yes. I think
7 I said yesterday you will want six months and I will
8 want six hours and we will try and reach a compromise.

9 MR. OLAH: Is that specifically
10 related to me, sir?

11 THE COMMISSIONER: Oh, no, sorry. I
12 am talking about counsel generally. We will try to
13 work out something, but remember that those counsel
14 who are coming at the end will have some time in the
15 course of argument because I certainly think argument
16 will take two weeks at least. It may take longer, I
17 don't know, but we will have lots of time to prepare.
18 But there is nothing wrong with your sitting down
19 some night when you have nothing to do and just going
20 to work on it.

21 MR. OLAH: Well, that doesn't happen
22 very often.

23 The other question I want to address
24 to you, sir, is this: Somewhere along the way it might
25 be helpful if we got some guidance from you as to how
you feel the ultimate report and the Court of Appeal's



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decision merge or interact.

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THE COMMISSIONER: Well, everybody is going to have to, if they put something to me that I don't think I can report on, I will tell them and they will have to tell me how they think I can do it.

7

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MR. OLAH: Did you want to have that with you, sir, during the course of argument?

11

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MR. OLAH: Because there are some general concerns that arise as a result of the Court of Appeal decision and how far your reporting function can go as opposed to prohibitions the Court of Appeal has imposed on you.

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THE COMMISSIONER: Yes.

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MR. OLAH: I am wondering if it would be worth addressing that issue separately.

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MR. OLAH: That's fine, sir.

THE COMMISSIONER: Because there will be some particular thing that some counsel will want to



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put to me, and if it occurs to me that it is something that I am not allowed to report on, I will ask him how he thinks I can do it and then he will have to tell me.

MR. OLAH: Yes.

THE COMMISSIONER: Okay. Now anything else?

MR. OLAH: One more thing: I was wondering if I could have your indulgence to ask the witness two very brief questions.

THE COMMISSIONER: Yes. All right.

Before you come on, Miss McIntyre.

CROSS-EXAMINATION BY MR. OLAH:

Q. Mrs. Bucci, from reviewing the schedule that your counsel supplied to us - by the way I have introduced myself to you. You know I act for Janet Brownless - it is evident that you were the team leader on the day shift preceding the death of Baby Miller.

A. Yes.

Q. And the question I have in relation to that is a general question really.

Were the syringes kept in the medication room?

A. Yes.

Q. And do you recall whether they



F14 1
2 were kept separately, the 1 cc. syringes kept separately
3 from the 3 cc. syringes?

4 A. Yes.

5 Q. Or were they all mixed?

6 A. No, they were separated.

7 Q. And were the 1 cc. syringes
8 kept in a bucket or a pail of some kind in the
9 medications room? That is the syringes in a packet.

10 A. I recall this tray that had
11 several compartments to it for the different sizes.

12 Q. It was kept in a tray?

13 A. A tray that had compartments
14 to it.

15 Q. Now let's deal first with the
16 day or the long day shift of Miller's demise. Do you
17 recall whether there was a shortage of 1 cc. syringes
18 that day or do you have no recollection?

19 A. I have no recollection.

20 Q. Generally over the course of the
21 nine months we are dealing with did you ever find that
22 you had to substitute in lieu of a 1 cc. syringe a
23 3 cc. syringe?

24 A. I don't remember.

25 Q. Do you ever remember that
occurring or you have no recollection of it?



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A. I have no recollection of it.

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THE COMMISSIONER: I am still not
sure which it is. I would have some trouble posing
the question myself. Is it the sort of thing you
would remember if it happened? Is it possible that it
might have happened and you don't remember it, or is it
likely that it did or did not happen?



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THE WITNESS: It might have happened
but I don't remember.

THE COMMISSIONER: Yes.

MR. OLAH: Q. On the other hand, do you
have any recollection of going the other way, when
you didn't have 3 cc syringes and you would have to
use a 1 cc syringe say several times to accomplish
the same feat, do you remember that ever
occurring?

A. Yes, I do remember that.

Q. All right, you have a specific
recollection of that occurring?

A. Yes.

Q. All right. And when you told
the Commissioner that you have no recollection
going the other way, that is, using a larger syringe
when you required a smaller one, is that because you
don't believe it ever happened or because you just
have no recollection one way or the other?

A. I don't remember it but it is
an awfully small syringe to get the quantity in
a larger syringe. Am I making myself clear?

Q. I'm not sure I understand.

A. The 1 cc syringe is only for
very small doses and you can't get the same amount



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or it wouldn't be as accurate measuring it into a
3 cc syringe.

Q. Well, again, I come back to the
question. Is that something you ever recall
occurring to you during the course of the nine months
we are talking about where you have had difficulty
in measuring?

A. I don't recall.

Q. You don't recall?

A. I don't recall.

Q. If you think it did happen do
you think you would remember?

A. I don't know.

Q. Okay. The other question I want
to ask you is, just turning to the Lombardo chart.
I was having a little trouble deciphering something
in the chart and I was hoping you could help me.
Have you got the chart there, Ma'am? If you would
turn to page 108, which is the flow sheet, and there
is, you will see that there are entries under the
column IV 8 hours?

A. Yes.

Q. Can you, first of all, tell us
what that column represents?

A. That's the total amount of



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intravenous fluid given in a shift.

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Q. And checking the IV and the sage pump in this case, would that be something that you would do on a regular basis during the course of your shift?

A. Yes.

Q. Would you be checking to see whether the sage pump was working properly and fusing well?

A. Hourly, yes, at least that.

Q. You would check that hourly?

A. At least hourly, yes.

Q. So, when you have the entry at 3:00 o'clock - is it 3:00 o'clock, the last entry there?

A. I'm not sure what that is.

Q. Do you think that would be an entry before the baby's death or after the baby's death?

A. I think it's after.

Q. And at that time you checked the sage pump, is that what that would suggest, the entry 8 or is that a calculation you made?

A. That's calculated from the fluid balance sheet, which is kept at the bed side.



BM/dg
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Q. But in any event you tell us
you would check the sage pump on a hourly basis?

A. Yes.

Q. Do you have a recollection
whether the sage pump was functioning well that
night and functioning at the rate that the doctor
has ordered, namely, one ml. per hour?

A. I recall having no problems
that night.

Q. So, can we take it fairly safely
that the infusion rate was that very, very slow
rate, namely, 1 ml. per hour?

A. Yes.

Q. The last thing I was confused
about in all of this is generally, I know you
don't recall whether you drew up heparin that
night or something else, generally what amount
would you use to dilute the heparin when you draw
up the solution?

A. As the order states.

Q. Well, in this case, the order
is at page 90. That would be 50 mls. of IV
solution. If you look at the top order, item
number three.

A. Yes.



BM/dg
G5

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Q. If you drew up heparin that night you would have mixed it in 50 mls. of IV solution?

A. That is correct.

Q. I'm sorry, 3,000 units, how many ampules would that involve, do you know?

A. I don't remember how much is in an ampule at the moment.

Q. I'm sorry, maybe Miss Cronk can assist me in that regard. We have had evidence on that I believe.

MS. CRONK: On heparin?

MR. OLAH: I don't know, have we?

MS. CRONK: It has been marked as an exhibit but the witness has already indicated today to Mr. Strathy that it is not the same form of ampule that she recalls being in use at the time.

MR. OLAH: Q. All right. Do you recall whether it would take one ampule or more than one ampule to arrive at the 3,000 units?

A. I think this is less than one ampule.

Q. Less than one ampule. So that assuming that you drew up heparin that night -

A. Yes.



BM/dg
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Q. And that assumption is fairly safe because we know that it has to be done every eight hours?

A. Yes.

Q. Am I correct on that?

A. Yes.

Q. So, it would have to have been done during the course of your shift?

A. I can't be sure.

Q. Six to eight hours?

A. Yes.

Q. That was a twelve hour shift you worked?

A. Yes.

Q. So, can we take it fairly safe that somewhere during the course of that night you would have drawn up heparin?

THE COMMISSIONER: If the baby had lived.

THE WITNESS: That is correct.

MR. OLAH: I'm sorry.

THE COMMISSIONER: If the baby had lived.

MR. OLAH: I'm sorry, that's true, if the baby had lived, yes.

THE WITNESS: Yes.

MR. OLAH: Q. Fair enough, but in



BM/dg
G7

1
2 any event the bottom line to all of this is that
3 even if there was a drug medication error, and I'm
4 not suggesting there was, but assuming the worst
5 scenario, because it was infusing at such a small,
6 slow rate, would I be fair in saying that probably
7 a very small amount of drug would have reached that
8 baby because of the slow infusion rate?

9 A. The required amount would have
10 infused into the baby.

11 Q. Well, we are talking about the
12 worst scenario situation.

13 A. Yes.

14 Q. Say 8:00 o'clock you mixed up
15 the heparin and into 50 mls. of solution?

16 A. Right.

17 Q. We know that from 8:00 o'clock
18 until 3:00 o'clock in the morning you have got
19 a lapse of seven hours?

20 A. Right.

21 Q. In other words, 7 mls. of
22 the solution would have reached that child?

23 A. That's right.

24 Q. Seven and a half?

25 A. That's right.

Q. And when you mixed the heparin



BM/dg
G8

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and the 50 mls. of IV solution do you shake it to make sure that there is proper mixing?

A. Yes.

Q. And do you do that from time-to-time as the night progresses to make sure that the two don't separate?

A. No.

Q. In your experience do they tend to separate?

A. No.

Q. So that would it be a fair suggestion, I don't know, please help me in this regard, to say that at the most approximately, if the worst scenario situation, if there had been a medication error, and in my view that is doubtful, unlikely, but nevertheless using the worst scenario situation only approximately one-seventh of the total solution would have reached the baby and probably one-seventh of the drug that was infused reach the baby.

A. All right.

Q. Thank you.

THE COMMISSIONER: All right, thank you, Mr. Olah. Miss McIntyre?

REEXAMINATION BY MS.MCINTYRE



BM/dg
59

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MS. MCINTYRE: Q. I have just got a few questions just like Mr. Olah.

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Mrs. Bucci, I want to ask you again about this anticoagulation record. I take it at this point you are not positive that there was such a record in use on Ward 4A?

5

6

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A. That's right.

8

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Q. But I take it that you at some point did use a record, whether it was Toronto General Hospital?

10

11

A. Yes.

12

Q. Is it possible also at Etobicoke General Hospital where you are presently employed?

13

14

A. Yes.

15

Q. And I take it in any event that heparin was not, and in particular on the Lombardo child, was not recorded on the Medication and Treatment record?

16

17

A. That's right.

18

19

Q. Can you explain why not? I take it that was the proper practice, was it not, to put it on the regular medication record?

20

21

A. I can't explain that, I don't know.

22

23

Q. You don't know why it wasn't.

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BM/dg
G10

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It was treated in a special category, though was it?

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A. Yes, it was.

4

Q. And the record that Mr. Roland referred to, do you still have the Lombardo chart in front of you?

5

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A. Yes.

7

Q. The lab record, do you know if that's the document that appears at page 104. I understand from Miss Thompson that this is the record, the lab record?

10

11

A. Yes.

12

Q. And the PT measurement near the bottom of the page, on page 104, is the measure of how well the heparin is working in effect?

13

14

A. Yes.

15

Q. And that's a measurement from blood tests that would be taken on the child?

16

17

A. Yes.

18

Q. I take it this record does not give us any indication as to when the heparin would have been changed?

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A. No.

21

Q. Mrs. Bucci, you told Mr. Hunt this morning that when the Lombardo child died that it made you question your own abilities

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BM/dg
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to make observations and it made you wonder why Phyllis Trayner had found the baby in distress when just a few minutes before you hadn't observed any difficulty. Did anyone ever question or criticize your care of the Lombardo child that night?

A. No.

Q. And do I understand that when you found out what the probable diagnosis was that you were satisfied that you had not failed to make proper observations that night?

A. Yes.

Q. Do I take it then that you understood that occlusion of the shunt would explain the fast change in the baby's condition?

A. Yes.

Q. Okay. And you told Mr. Hunt that you remembered the Lombardo death well and he suggested to you that one reason was the so called traumatic reversal in the child's condition. Is another reason because this child was under your care when it died?

A. Yes.

Q. And is another reason because it was one of the first children to die under your care on that ward, if not the first?



BM/dg
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A. Yes.

Q. And in fact one of the only children to die while you were on shift on Ward 4A?

A. Yes.

Q. Can you tell us, if you had 28 children die while you were on shift, do you think you could remember the details of all their deaths, like you can remember the Lombardo death?

A. No, not each one.

Q. Thank you very much.

THE COMMISSIONER: Miss Cronk.

MS. CRONK: Thank you, sir.

REDIRECT EXAMINATION BY MS. CRONK

MS. CRONK: Mr. Registrar, could you show the witness, if you would please, exhibit 291. That sir, you may remember is the book of extracts from the Policy and Information Manual, Department of Nursing at the Hospital For Sick Children.

THE COMMISSIONER: We seem to be short a copy.

Perhaps we can do it this way, I will read it with the witness.

I'm going to refer you first, Ms. Bucci,



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to section 18.07 of the Manual. I should perhaps properly ask you first, have you ever before seen the Policy and Information Manual, the department of nursing at The Hospital For Sick Children?

A. I recall seeing it when I was there.

Q. And that was kept on the ward at the time?

A. Yes.

Q. And as a nurse who was permanently assigned at that time to the ward and to a team on Ward 4A you would have had occasion to see the manual from time to time?

A. Yes.

Q. All right. Referring to section 18.07 which refers to intravenous heparin, could you read out for us please subsection 2 under that section?

A. "The dose of heparin must be checked by two qualified nurses, one of whom must be registered."

Q That appears to require, as you have suggested previously Ms. Bucci, that in the drawing up of a dose of intraveneous heparin it must be double checked by two nurses?



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2343

BM/dg
G14

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A. That's right.

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Q. I am going to refer you now

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as well to section 17.06 of the manual - I'm sorry

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17.07 of the index which deals with her heparin syringe

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I draw your attention in this case to the fourth

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sub-paragraph, could you read that out for us as

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well, please?

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A. "This syringe must be labelled with the time and date of preparation and the dilution of heparin as well as the signature of the nurse preparing it."

Q. Do I correctly take it from that provision, Ms. Bucci, that the syringe which would be attached in this case to the Sage pump of the child, if that is the way the heparin was being administered, would be labelled first with the time and the date that the dose was being given?

A. Yes.

Q. The fact that the dose, the nature of the preparation was heparin?

A. Yes.

Q. It would as well the dilution of heparin?

A. Correct.

Q. And that would be determined by the doctor's order?

A. Yes.

Q. And finally it would bear and was required to bear the signature of the nurse who had drawn the dose up?

A. Yes.



H.2

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Q. And we know that dose had to
be double checked by two nurses?

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A. Right.

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Q. In that situation - and I note
further from that subsection that there is no
indication, at least in that provision, that the
syringe had to be, the label on the syringe had to
be double signed, that is by the two nurses who had
been involved in checking the dose?

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A. That's right.

11

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Q. But it did require the
signature of at least the one who had actually drawn
the drug up?

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A. Yes.

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Q. Now you have told us several
times that it is your recollection that the drug in
fact had to be both double checked and as well that
it had to be double signed by both nurses involved
in that procedure?

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A. Yes.

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Q. And there is now an issue over
the anticoagulation form that may or may not have
been in use at the Hospital at that time on that ward.
Was it also part of the procedures that applied that
once the syringe was attached to the Sage pump that



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a sticker was placed on the buretrol?

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A. Yes.

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Q. I am sorry, the sticker was placed on the syringe?

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A. Yes.

7

Q. Would that be the label that is being referred to in that section of the Policy Manual?

8

9

A. Yes.

10

Q. Is it possible that the double signature that you recall as having been the practice on the ward would have been a double signature on that label on the syringe, is that possible?

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A. Yes.

14

Q. Are you certain in your own mind that insofar as you were concerned that the procedure was that when drawing up intravenous heparin there had to be a double signature of the two nurses involved?

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A. Yes.

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Q. Would I have it correctly then that the double signature, that is the two signatures, would be recording either on the form that may or may not have existed, and we are not sure at all now that it is at the time?

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A. Yes.

Q Or it may have been on the actual label on the syringe?

A. Yes.

Q We have seen before, although perhaps there is no reason that you should be aware of this, that procedures outlined in the manual at the Hospital had on occasion some variation in practice, in actual practice on the ward, and I suggest to you that if it was the case that double signatures went on the sticker, that may have been done simply out of an abundance of caution although the Manual required only one?

A. That's right.

Q We have also had, as I understand your evidence, there is doubt in your own mind as to whether or not during the course of that 12-hour long night shift the night that Stephanie Lombardo died, that you in fact did draw up heparin, you are not at all sure that that happened?

A. That's right.

Q Mr. Olah suggested to you a few moments ago, and indeed you may recall that we discussed it a few moments earlier that because it was a 12-hour night shift that it would of necessity



H.5

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mean that the syringe on Stephanie Lombardo's Sage pump had to be changed at least once during that shift, do you remember the suggestion being made to you?

6

A. Yes.

7

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Q. And you have told us you think that it was required that it be changed every six or eight hours?

9

A. Yes.

10

11

Q. When did you come on for duty at the beginnong of that shift, do you recall?

12

A. 7:15, 7:30.

13

14

Q. And that would be the normal time for the start of the long night shift?

15

A. Yes.

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17

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Q. And you have told us several times that there was no sign of any difficulty with respect to this child until 3:30 in the morning, do I have that correctly?

19

A. That's correct.

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Q. Without professing any expertise in pure mathematics that suggests to me that more than eight hours would have had to expire between the beginning of that long night shift and the time when any first sign of difficulty arose with Stephanie Lombardo?



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A. Yes.

Q. I suggest to you therefore that the likelihood is whether the rule was that it be changed every six hours, or whether it be changed every eight hours, but it should have been changed prior to 3:30 in the morning?

A. Right.

Q. And if that was the procedure of which you were aware at the time, I suggest to you that it is likely that it was changed by you during the course of that time, before 3:30 in the morning?

A. Yes.

Q. Is that fair?

A. Yes.

Q. And I suggest that to you because you have told us previously that it was an unusually slow night?

A. Yes.

Q. You certainly were not run off your feet?

A. That's right.

Q. With the patients that you had?

A. That's right.

Q. There were only two of you



H.7

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that were on 4A?

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A. Yes.

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Q. And there would be no reason that you can now think of as to why another nurse would be required to change that syringe instead of yourself?

7

A. That's right.

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Q. You told us yesterday, Ms. Bucci, and you have repeated it in your discussion with Mr. Hunt today, that when you learned of the potential difficulty concerning Stephanie Lombardo's shunt, that is the possibility that it had occluded, you were reassured as to why she had died; do you remember saying that yesterday and then again today?

15

A. Yes.

16

17

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Q. You don't remember when you first learned that, and you don't remember from whom you first learned it. You told Mr. Shanahan as I understood it that you definitely learned it before you knew that Stephanie Lombardo's body had been exhumed and that digoxin had been found in various tissue samples taken from her body?

22

A. Yes.

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Q. So you knew the possible explanation, the shunt discussion had been put forward



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to you, I suggest well in advance of knowing that digoxin was found in that child?

A. Yes.

Q. And am I correct as well that at the time you were caring for the child, that is as far back as December the 22nd, you knew digoxin had never been prescribed for her?

A. Yes.

Q. In light of those two facts; the explanation that was advanced and then learning subsequently after that that digoxin was in fact found in her body, can you tell me when you learned that did that cause you some degree of discomfort?

A. Yes.

Q. Were you shocked to learn that digoxin was in fact found in her body?

A. Yes.

Q. We agree, Ms. Bucci, that an occluded shunt, assuming that the shunt was occluded and it may have been.

A. Yes.

Q. Assuming that it was, that that would not account for the presence of digoxin in the tissue samples from that child given that the drug had never been prescribed for her?



H.9

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A. That's right.

3

Q. So it doesn't help us resolve

4

that question?

5

A. That's right.

6

Q. And you can't help us resolve

7

it because you have told us you did not give digoxin
to that child before she died?

8

A. That's right.

9

Q. Nor did you see anyone else do it?

10

A. That's right.

11

Q. Nor did you learn of anyone

12

else doing it?

13

A. That's right.

14

Q. Can we examine one other aspect

15

of the matter. We have heard evidence from another

16

witness that the drugs in the medication rooms on

17

Wards 4A and 4B were stored in boxes. By that I mean,

18

if you are talking about an ampule of a drug that

19

they came in a little box; does that accord with your
recollection?

20

A. Yes.

21

MS. CRONK: Could we have Exhibit 131,
please, Mr. Registrar?

22

Q. Ms. Bucci, we have marked as

23

an exhibit a sample of a box of paediatric digoxin

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H.10

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which we are told was in use at the time on Wards
4A/4B and if we could deal with that one first.

4

A. Yes.

5

6

Q. Am I correct that the outside
of that box bears, in very large black letters, the
word "Lanoxin"?

7

8

A. Yes.

9

Q. And that is the trade name for
digoxin?

10

A. Yes.

11

12

Q. And the background colour of
the box is white so that the black printing stands out?

13

A. Yes.

14

Q. And as well in a black box with
white lettering the word "paediatric" is shown?

15

16

A. Yes.

17

Q. And then immediately below the
word Lanoxin again in black printing we see
"injection of digoxin"?

18

19

A. Yes.

20

Q. And then a description of the
dose?

21

22

A. Yes.

23

Q. And various other information
including the identity of the manufacturer of the drug?

24

25



H.11

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A. Yes.

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Q. And I suggest to you that the

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size of the printing and the colour of the printing

5

on the box leaps out at you when you first look at

6

it and identifies the ampules in this box as being

7

Lanoxin or digoxin?

8

A. That's right.

9

Q. And as well it is of a

paediatric concentration?

10

A. That's right.

11

Q. And similarly if we look at the

12

box which contains the adult size of ampules, that

13

we are told was also in use at that time on the ward,

14

the background colour of the box is white?

15

A. Right.

16

Q. This time the printing is all

in red?

17

A. Yes.

18

Q. And again in very large

19

lettering do we see the word "Lanoxin"?

20

A. Yes.

21

Q. Did you know at the time that

the trade name for digoxin was Lanoxin?

22

A. Yes.

23

Q. And you knew that on December

24

22nd?

25



H.12

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A. Yes.

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Q. And immediately below the word

4

"Lanoxin" we see - it would be helpful if I showed

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you the version in English and it would be helpful to

6

me; but underneath it "injection of digoxin" again in

7

large red print but slightly smaller than the word

8

Lanoxin itself?

9

A. Yes.

10

Q. And then in very dark print

11

the concentration in milligrams per millilitre of

the ampules contained in the box?

12

A. Right.

(2)

13

Q. And these, help me with this,

14

were these the type of boxes as you recall it in

15

which digoxin was stored in the medication rooms on

4A and 4B at that time, December 22nd?

16

A. Yes.

17

Q. So would I be correct then that

18

if one were intent upon reaching for digoxin, or of

19

searching out for digoxin in the medication room, that

20

one would reach up and fetch one of these boxes,

21

either the adult preparation or the paediatric

depending on what you wished to take?

22

A. Yes.

23

Q. Given the size of the lettering

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A. Yes.

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Q. It would be difficult to confuse

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a box containing heparin ampules for a box containing

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Lanoxin ampules given the distinctiveness of the

12

packaging?

13

A. Yes.

14

THE COMMISSIONER: We didn't have a box though of heparin, did we? You didn't show her, these were boxes were they not of digoxin?

15

16

MS. CRONK: I am sorry, I can rephrase the question, sir, you are quite right.

17

18

THE COMMISSIONER: Yes.

19

MS. CRONK: Q My point simply is this, Ms. Bucci, that in picking up either of those two boxes, the ones containing Lanoxin, I would show you one of heparin if we had it, but we don't.

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21

22

A. Yes.

23

Q In picking up either of the

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two that contains digoxin, it would be very difficult unless one didn't look at the lettering on either side of the box, to think it contained something other than Lanoxin or digoxin?

A. Yes, it was difficult to confuse the two.

Q. It would be difficult --

THE COMMISSIONER: Can you tell me something about - do you remember anything about what the box was for heparin?

THE WITNESS: Heparin, I think I recall being heavy darker lettering, not as thin writing.

THE COMMISSIONER: Did you ever have any difficulty in confusing the two?

THE WITNESS: No.

THE COMMISSIONER: Did you ever have any problems?

THE WITNESS: No.

THE COMMISSIONER: Have you ever taken the wrong one and put it back again, anything like that?

THE WITNESS: I can't say if I have ever made the error.

THE COMMISSIONER: No, no. I mean,



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quite often we do take things from shelves and find we have got the wrong - it is quite easy to confuse one type of Campbell's soup from another. Is it easy to confuse, that is all I am getting at, the heparin and the digoxin, either adult or paediatric?

THE WITNESS: I can't say. The wrong box could have been picked up if you were not reading it properly, but my common practice is to read the ampule itself and not the box.

MS. CRONK: Q. Your common practice then was not to read the lettering on the box?

A. Well, you know, I would hopefully take the right box and then take the ampule out and read the ampule itself.

Q. I didn't mean to be unfair in the suggestion. My point only was that if one reached for a box. Let us put the example that if one were intending to reach for heparin, but in fact got in their hand a box containing ampules of digoxin, that if you did look at it, and indeed even glanced at it, the size and the colour of the print on the digoxin boxes is such that it would be readily and immediately apparent that it contained Lanoxin or digoxin?

A. That's right.

Q. I am going to examine another



H.16

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A. Yes.

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A. That's correct.

16

17

in colour?

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A. That's right.

19

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as well?

21

A. That's right.

22

distinguish?

23

A. That's right.

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H.17

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Q. There would be nothing visually apparent in that situation to cause someone to question what was in the syringe unless they had seen what was put in the syringe?

A. That's right.

Q. So if you as the nurse in charge of the care of Stephanie Lombardo that night had left the room, Room 418, as we know you did, throughout the course of the evening and had come back in and in the interim someone either by accident or design had placed digoxin in the syringe of her Sage pump apparatus, you would not be able to tell I suggest to you visually that that had been done?

A. That's right.

Q. Is that so?

A. Yes.

Q. May we look as well at the possibility further of confusion of the two drugs. I am going to suggest to you to accept this hypothetical for a moment, that digoxin was confused that night for heparin at a time when heparin was being drawn up in that syringe to refill the Sage pump apparatus. Do you accept that?

A. Yes.

Q. An accident happened.



H.18

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A. Right.

3

Q. At least they were confused.

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It seems to me in that situation a number of things would have had to have happened in order to make that possible, and I would like to obtain your views and your assistance on it.

It seems to me first, given what we have just looked at, the boxes of digoxin, that someone would have had to take the digoxin from one of those boxes, thinking that it was heparin, without looking at the lettering on the digoxin box, without realizing that despite the lettering and the colouring that they had digoxin instead of heparin?

14

A. That's right.

15

Q. They would have had to make that mistake, is that right?

16

A. Yes.

17

18

19

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Q. And as well we have heard in prior evidence from another witness, and we have discussed it this morning, that the drugs in those medication rooms were not controlled drugs, they were stored alphabetically. So I am going to suggest to you that someone would have to reach for a box of heparin ampules, but instead of getting heparin would have to end up in one of two places either at "D" under the digoxin or at "L" under Lanoxin?

A. That's right.



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EMTrc

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All right?

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A. Yes.

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Q. They would have to do that?

All right?

A. Yes.

Q. And then thirdly you have told us that the drug would have to be drawn up - in the belief that it was heparin it would have to be drawn up in a 3 cc. syringe as you recall it?

A. Yes.

Q. All right. And in order to do that obviously you would have to open the box containing the ampules of the drug, take out the ampule and physically draw it up in the syringe?

A. Yes.

Q. All right. And you have told us it was your particular practice to always read the lettering on the ampule? Do I have that correctly?

A. Yes.

Q. All right. So that at that stage of the procedure I am going to suggest another mistake would have had to have been made, and that is that the person who made the error would have had to have taken the ampule out of the box, drawn it up into the 3 cc. syringe and then in the time that took never have read the lettering on the ampule or if they did read it, misread it. That is another mistake that



I2 2 would have to be made, isn't that so?

3 A. Yes.

4 Q. And you have also told us, and
5 the policy manual confirms, that we just looked at,
6 that the drawing up of intravenous heparin requires
7 double-checking by two nurses?

8 A. Yes.

9 Q. All right. So I am going to
10 suggest to you that the three errors that I have just
11 described to you would have had to have been made by
12 two people?

13 A. Yes.

14 Q. The second nurse in the room
15 observing the procedure would have had to not detect
16 the error anywhere along the road in that procedure so
17 far?

18 A. That's right.

19 Q. And that, by my count, takes us
20 up to six errors at that stage alone, and I am going
21 to suggest one more step to you and I ask you to tell
22 me whether you agree or disagree.

23 You have told us that heparin, as you
24 recall it, had to be double-signed, and we have
25 explored this afternoon that that could have meant a
double signature on the label on the syringe or on an



I3 1
2 anticoagulation form, although you are not sure it was
3 in use. Whichever it was, I am going to suggest to
4 you then there are another two errors, and that is that
5 the two nurses who signed for the drug, if there
6 were two, had to sign for heparin believing it was
heparin when in fact they had digoxin?

7 A. That's right.

8 Q. In the face of all those errors,
9 Ms. Bucci, and recognizing what you told us earlier
10 that the night was unusually slow --

11 A. Right.

12 Q. -- it wasn't an emergency
13 or frenetic situation prior to 3:30 in the morning?

14 A. That's right.

15 Q. No panic afoot because of any
16 child's condition?

17 A. That is right.

18 Q. I suggest to you that in those
19 circumstances if the heparin had been intended to be
20 drawn up before 3:30 in the morning, that that's a
21 great many errors that would have had to have been
22 made for digoxin to be mistaken for that drug.

23 A. That's right.

24 Q. I am suggesting to you that that
25 many errors in the circumstances that applied that



1
I4 2 night would make it most improbable that the two had
3 been confused?

4 A. That's right.

5 Q. You don't have any difficulty
6 with that?

7 A. No.

8 Q. And then finally can we examine
9 one other aspect of the matter that night, the layout
10 of Room 418, and you have discussed this with a number
11 of people so I won't take too much of your time.

12 You have told us that you were at
13 the nursing station with a friend, Paula Giffin, when
14 you became aware that the child got into difficulty?

15 A. Right.

16 Q. That was because Mrs. Trayner
17 came to the nursing station or at least the front of it
18 and called out to you?

19 A. Right.

20 Q. You told us you can't remember
21 if the blinds on the observation window from the
22 nursing station into Room 418 were open or not at that
23 time, but you do remember Paula Giffin waving goodbye
24 to you from the nursing station when you were in 418,
25 so you know they were open then?

A. Correct.



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Q. All right. Did you at the time
your friend was waving goodbye to you see her handle
the blinds in any way? Did you see her move them in
any way?

A. No.

Q. All right. You did not --

A. No, I didn't see --

Q. -- or you don't remember one way
or the other?

A. I didn't see her handling the
blind.

Q. All right. And you have told
us that you can't remember whether you, while you were
at the nursing station, looked into Room 418. Do I
have that correctly?

A. That's right.

Q. All right. And you have told
us, at least you told Ms. McIntyre that before
Stephanie Lombardo went into her arrest, her room,
Room 418, was quite dark. You said you knew that be-
cause you remembered as soon as the arrest occurred
the lights had to be turned on?

A. That's right.

Q. Did I hear that correctly
yesterday?



1

I6

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A. Yes.

3

Q. So that before 3:30 in the morning the room was, in your words, quite dark?

4

A. Dim I think I said.

5

6

Q. I think you said quite dark, but in any event the lights you remember being turned on after the arrest occurred?

7

8

A. Right.

9

10

11

Q. All right. And you have told us finally that Stephanie Lombardo was in an isolette in the middle bed on the right-hand side under the nursing station. Do I have that correctly?

12

13

A. Yes.

14

15

16

Q. I am going to show you a diagram, Ms. Bucci, that was used concerning another child, and I would just ask you to ignore it. It was used in the context of Justin Cook.

17

18

19

20

Do I have it then on your evidence that that night Stephanie Lombardo was in the same bed as this diagram depicts Justin Cook; that is the middle bed on the right-hand side of the room beside the nursing station?

21

A. That is right.

22

23

Q. Where was your other patient in Room 418 that night, do you remember?

24

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A. We pushed her aside when the arrest happened. I think she was - I'm not positive, though - just on the right-hand side from where I am sitting now of Stephanie.

Q. Was she on the right side of the room?

A. Yes.

Q. Was she in the top bed in the room?

A. The top.

Q. That is the one on the north side or the south side?

A. The top, the north.

Q. All right. So there were two patients on the right-hand side?

A. Yes.

Q. And this room was a six-bed room?

A. Right.

Q. Am I correct then that whether or not there was a patient in it, and we know from what you just said there wasn't that night --

A. Yes.

Q. -- there would have been another bed immediately in front of Stephanie's bed as you



I8

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2

looked into that room?

3

A. Yes.

4

Q. All right. Do you recall now what kind of bed that was that was in -- that front bed?

5

6

A. It was a baby crib.

7

Q. All right. I am not going to suggest that it did so totally, Ms. Bucci, but I am going to suggest that prior to the time when Stephanie Lombardo went into an arrest prior to 3:30 in the morning the fact that there was another bed adjacent to her bed in front of it would to some degree obstruct the view into that room from the doorway into Room 418; isn't that so?

14

A. It's possible, yes.

15

16

Q. Isn't that in fact so given the angle of the doorway into the room?

17

18

A. I can't say for sure. It's a small bed.

19

Q. It's possible?

20

A. Yes.

21

22

Q. All right. And I suggest to you that that possibility is perhaps rendered more

23

likely given what you have told us that the room was darker than it was when the arrest started?

24

25



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A. Yes.

3

Q. Visibility would be cut down

4

by that?

5

A. Yes.

6

MS. CRONK: Could I have your
indulgence, sir?

7

THE COMMISSIONER: Yes, certainly.

8

You said when the arrest started, but

9

I think you meant after the arrest had started. It

10

was darker than it was because it was when the arrest
started that you turned up the lights.

11

12

MS. CRONK: Yes, you're quite
right.

13

14

15

16

Q, When Paula Giffin your friend
who was there that night waved goodbye to you from
the nursing station, did she rap on the window or
knock on the window in any way to get your attention?

17

A. I think she did, yes.

18

19

Q. That is how she got your
attention?

20

A. Yes.

21

22

23

Q. So you didn't just glance up
and happen to see her standing there? Your attention
was specifically drawn to the window; you saw her
waving goodbye?

24

25



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A. Right.

3

Q. I take it in an arrest situation

4

it is not a common thing to be looking out the

5

windows unless there is some reason to do so?

6

A. That's right.

7

Q. All right. From what you told

8

us you were at the nursing station sitting down having

9

a coffee with someone else. In your experience that

10

night it wasn't a common thing to be looking into

those windows either?

11

A. That's right.

12

MS. CRONK: Thank you very much,

13

Ms. Bucci. You have been a considerable help to us.

14

THE COMMISSIONER: Thank you.

15

Now, Miss Cronk?

16

MS. CRONK: Sir, our next witness is

17

Mrs. Palmer, who I believe is here. I would ask her

to come forward.

18

THE COMMISSIONER: Yes.

19

PATRICIA PALMER, Sworn

20

DIRECT EXAMINATION BY MS. CRONK:

21

Q. Ms. Palmer, as I understand it

22

you obtained your high school education in Hamilton

23

and you trained as a Registered Nurse at The Hospital

24

for Sick Children as it happens?

25



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2

A. Correct.

3

Q. Is that correct?

4

A. Yes.

5

Q. You graduated as a Registered Nurse in September 1968, from a three-year diploma course. Was that offered by the Hospital?

6

7

A. Yes, that's correct.

8

9

10

11

Q. And thereafter, I have been informed, you worked in the Pediatrics Surgery Unit of the University of Alberta Hospital for some six months. Is that correct?

12

A. Longer than that. It was the better part of a year.

13

14

Q. All right. That started as soon as you graduated?

15

A. That's correct.

16

17

Q. And the division was Pediatric Surgery?

18

A. That's correct.

19

Q. All right. Then after you completed your year's term there or the length of your term there, you accepted a position at The Hospital for Sick Children on Ward 10A, then an infant and toddler surgery ward; is that correct?

20

21

22

23

A. That's correct.

24

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Q. And you stayed there, as I understand it, until 1973 when the ward was closed?

A. Right. That's correct.

Q. Thereafter, as I understand it, you left The Hospital for Sick Children for a brief period of time but returned the following year early in the year as a staff nurse in the Intensive Care Unit?

A. That's correct.

Q. And from 1974, for the next two years, did you remain as a full-time staff nurse in the Intensive Care Unit of The Hospital for Sick Children?

A. Yes, I did.

Q. Then at the expiry of that two-year period did you transfer your responsibilities to a per diem basis at The Hospital for Sick Children and start to work on a per diem basis?

A. I have lost you there. I went from Intensive Care to Post-anaesthetic Room.

Q. All right.

A. Yes, and then I transferred to a per diem.

Q. All right. So that I understand it, you spent the better part of two years a full-time staff member in the Intensive Care Unit?



I13

1

2

A. Correct.

3

Q. You then transferred to the
Post-anaesthetic room?

4

A. Correct.

5

6

Q. That is a full-time staff
member again?

7

A. Yes, it was.

8

9

Q. You then went on a per diem
basis?

10

A. That's correct.

11

12

Q. How long did you remain a
member of the staff of that ward, the Post-anaesthetic
Ward, on a per diem basis?

13

14

A. No, it was full time in the
Post-anaesthetic Room.

15

Q. All right.

16

17

A. And then per diem was, oh, I
would say approximately three and a half years.

18

19

Q. By per diem do you mean you
could be called in to work as a relief nurse on any
floor of the Hospital?

20

A. That's correct.

21

22

23

Q. And were you from time to time
called in to work on Cardiac Ward 5A and then subse-
quently Wards 4A and 4B as a per diem relief nurse?

24

25



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A. On occasion I was, yes.

3

4

Q. And were you still performing that function and working in that role through the period July 1980 through to the end of March 1981?

5

6

A. Yes, I was.

7

8

Q. In the latter part of the spring of 1981, the end of March, did you resign from The Hospital for Sick Children?

9

A. Yes, I did.

10

11

12

Q. Have you continued to work in nursing since the spring of 1981 at various hospitals and various nursing facilities throughout the city and province?

13

14

A. Yes, I have.

15

16

17

Q. All right. As I understand it, Ms. Palmer, you worked on a per diem relief basis on Cardiac Ward 4A on the long day shift of Saturday, March 21, 1981?

18

A. That's correct.

19

20

21

Q. And we know from other evidence that it was during the course of the long night shift that night that a patient by the name of Justin Cook died.

22

23

24

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Could I ask you to turn to Exhibit 32A.

Mr. Registrar?



1
I15 2 I am going to show you, Ms. Palmer,
3 a volume of exhibits before the Commission that con-
4 tains the assignment book for Ward 4A for the day
5 that I am interested in, Saturday, March 21st.

6 A. Yes.

7 Q. Could I ask you turn to Tab 13,
8 please.

9 A. Yes.

10 Q. And to the second from the
11 last page, page 178. Do you have that?

12 A. 178, yes.

13 Q. This contains the staffing
14 assignments for the long day shift on March 21st,
15 Ms. Palmer, and I'm going to suggest that until three
16 o'clock in the afternoon on that day you had
17 assigned to you, to your care, two patients in Room 421
18 and two in Room 418.

19 A. Yes.

20 Q. And neither of the patients in
21 Room 418 assigned to your care were Justin Cook.

22 A. That is correct.

23 Q. You had two other patients?

24 A. Yes.

25 Q. And then after three o'clock in
the afternoon your assignment, as I read the entries,



1

I16 2 changed such that you were assigned three patients in
3 Room 418 and those in 421 previously assigned to you
4 were reassigned to someone else?

5

A. That's correct.

6

7

8

Q. So that from and after three
o'clock in the afternoon until the end of that long
day shift you had three patients in Room 418, again
none of whom was Justin Cook?

9

A. That's correct.

10

11

12

Q. In charge of the ward that day,
according to the assignment book, was a ~~woman~~ by the
name of Ms. Mandal.

13

A. According to the assignment
book, yes.

14

15

16

Q. And according to the assignment
book a Ms. Cooney was also working that day and Mrs.
Scott.

17

A. Yes.

18

Q. Do you see those entries?

19

A. Yes.

20

21

22

Q. And according to the assignment
book Mrs. Scott, after three o'clock in the afternoon -
well, indeed for the entire day - had three patients
in Room 418, including Justin Cook?

23

A. Correct.

24

25



I17

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2

Q. Is that correct?

3

A. Yes.

4

Q. And am I correct further in suggesting, Ms. Palmer, that after 3:00 p.m. there were a total of six patients in Room 418, including Justin Cook, although prior to 3:00 p.m. there had only been five?

8

A. I can recall there being six patients at one point but I can't recall there being five.

10

11

Q. All right. Well, I'm sorry, let's just take a look at the three o'clock period. We know that you have three and Mrs. Scott has three. My only point is that the room is at full complement: there are six patients in a six-bed room?

12

13

14

15

A. Yes, correct?

16

17

Q. Ms. Palmer, I am going to show you a sketch much like the one I just reviewed with the prior witness of Room 418.

18

19

A. Yes.

20

21

22

23

24

25

Q. I don't suggest it is to scale or that its artistry is even particularly expert. We know from prior evidence that Justin Cook was in the middle bed on the right-hand side of the room, on the nursing station side. Does that accord with your



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recollection?

3

A. Yes, it does.

4

Q. Does the diagram accurately depict the location of your three patients from three o'clock onward?

5

6

A. As far as I recall, it does, yes.

7

8

9

Q. All right. And of necessity it then means, does it not, that the two beds closest to the doorway into the room were occupied by patients of Mrs. Scott --

10

11

A. That's correct.

12

Q. -- the other nurse assigned to that room?

13

14

A. Yes.

15

Q. Did you know any of the other women that you were working with that day, Ms. Palmer, prior to reporting for work?

16

17

A. No.

18

Q. Do you know today Ms. Mandal, Mrs. Scott or Ms. Cooney on a personal basis?

19

20

A. No, I do not.

21

Q. Would you recognize them if they were sitting here today?

22

A. I might recognize -- I would recognize Mrs. Scott but I would not recognize the others.

23

24

25



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Q. All right. Is that because of recent publicity concerning the evidence of Mrs. Scott at these hearings or because you have an independent recollection of Mrs. Scott?

A. No, only because of recent happenings.

Q. All right. We know from Justin's medical chart, Mrs. Palmer, that at 6:00 p.m. he had what could be termed as a blue spell, he became very pale and cyanotic, according to the medical chart. Were you in Room 418 attending to your patients at 6:00 p.m. on Saturday, March 21st?

A. Yes, I was.

Q. What were you doing?

A. I can't recall. I was tending to my patient, I don't know whether I was feeding her or him or whether I was changing a diaper but I was at a bedside.

Q. Do you remember which bed you were at?

A. This one right here.

Q. You are pointing to the bed immediately across from Justin Cook?

A. That's correct.

Q. Who else was in the room at



Palmer, dr.ex.
(Cronk)

1

2

the time, this is at 6 o'clock?

3

A. I can't recall.

4

Q. Do you remember anyone else
being there?

5

6

A. Oh, certainly, yes. At
6 o'clock?

7

Q. At 6 o'clock.

8

A. Justin Cook's mother was in
the room. She was sitting in a chair giving him a
bottle and her girlfriend was sitting in a chair
beside her.

11

12

Q. Were there any other nurses
in the room other than yourself?

13

A. I can't recall.

14

Q. When you say that Mrs. Cook
was sitting in a chair giving Justin a bottle, where
was her chair located, was she at the nursing station
side of his bed or at the other end?

17

18

A. No, at the other end.

19

Q. Was her chair facing you or
did she have her back to you?

20

A. She had her back to me.

21

Q. Could you see Justin Cook
from where you were standing at the other bed?

22

23

A. I could see the top of his

24

25



1
2 head, the back of his head, but that was about all I
3 could see.

4 Q. Aside from Mrs. Cook and her
5 friend, do you remember any other nurse being in the
6 room?

7 A. I can't recall her actually
8 being there but I can remember her running over to
9 them, so, she must have been there on the other side
10 of her bed.

11 Q. All right. Well, help me
12 with that. please, what do you remember happening
13 around 6 o'clock?

14 A. I recall Justin Cook's
15 mother feeding him and she was having a conversation
16 with her friend, I noticed that, and then I suddenly
17 saw the nurse run from that corner by the door over
18 towards her and taking Justin Cook out of her arms.

19 THE COMMISSIONER: The nurse being
20 Mrs. Scott, is that who you are talking about?

21 THE WITNESS: I can't recall who it
22 was.

23 MS. CRONK: Q. You have told us that
24 you know today what Mrs. Scott looks like. I take
25 it you are simply saying that you simply can't remember
if it was Mrs. Scott who ran over to the bed?



1

2

A. No, I can't.

3

Q. But you know it was a nurse?

4

A. It was a nurse.

5

Q. And do I have it correctly

6

from what you have said that it was a nurse who was involved in caring for a patient in the room just

7

before she ran over to Mrs. Cook?

8

A. Oh, yes, it was Justin Cook's

9

nurse.

10

Q. All right, thank you.

11

A. That I remember.

12

Q. And if the assignment book

13

indicates that that was Mrs. Scott may we safely assume it was Mrs. Scott who noticed some difficulty with

14

Justin Cook and ran over to his mother to fetch the

15

baby?

16

A. That sounds fair enough.

17

Q. Were you involved in any of

18

the activity which followed to assist Justin Cook

19

after his blue spell began?

20

A. After he was successfully

21

resuscitated one of the nurses turned to me and asked me to go out to the desk and bring in some drugs.

22

Q. All right. Well, stop

23

there for a moment. Let's talk about the blue spell

24

25



1
2 itself. Were you involved as a nurse in the efforts
3 to assist the child during that spell?

4 A. No, I was not.

5 Q. What were you doing?

6 A. I stayed with my child.

7 Q. You stayed in Room 418?

8 A. Right.

9 Q. Did anyone come into the
10 room that you now recall other than Mrs. Scott the
11 nurse who was taking care of the patient?

12 A. Several nurses and several
13 doctors came into the room. The nurses came in first
14 and the doctors came very shortly afterwards.

15 Q. Do you recall who any of the
16 doctors were or who any of the nurses were by name?

17 A. No, I do not.

18 Q. While you were in the room
19 during the course of the assistance for Justin while
20 that spell was going on did you see anyone giving any
21 medication to the baby, to Justin?

22 A. Yes, I saw medications being
23 given to him.

24 Q. And then after the blue spell
25 ended you have told me that a nurse turned to you and
asked you to go and get some drugs?



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A. That's correct.

3

Q. Can you tell me please

4

exactly what happened?

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A. Exactly what happened?

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Q. As best as you can recall it.

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A. I can recall hearing the

8

doctors ask the nurses to have some ampules of a
certain drug on hand for future spells should they

9

occur and one nurse turned to me and asked me if I

10

would go to the nursing station and ask one of the

11

nurses who was there to get them for me.

12

Q. Let me stop you there for

13

a moment.

14

A. Yes.

15

Q. Do you remember the name of

the drug that the doctor asked for?

16

A. No, I do not.

17

Q. Do you remember the nurse

18

who turned to you and asked you to go and get the
drug?

19

A. No, I do not.

20

Q. Was it the same nurse who

21

had been caring for Justin Cook or was it another?

22

A. I can't recall.

23

Q. All right. Do you recall

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1
2 the doctor at the time that he indicated that he
3 wished, I think you said some ampules to be kept by
4 their bedside, indicating that he wished a syringe or
5 syringes to be brought to the room as well?

6 A. I don't recall that.

7 Q. Do you remember any reference
8 to a syringe by the doctor at that time?

9 A. No, I don't.

10 Q. All right. When the nurse
11 turned to you, whoever it was, and asked you to go and
12 get the drugs, did she ask you to get a syringe or
13 syringes at the same time?

14 A. No, she didn't.

15 Q. Do you remember what the drug
16 was that she asked you to get as opposed to the one
17 that the doctor asked the nurses to have at the bed-
18 side?

19 A. I don't remember the name of
20 the drug, I never have, but I do remember, even when
21 I was first questioned it was the same drug that they
22 had administered after his blue spell and I recall
23 hearing the doctor state the name of that drug and it
24 was the same drug that the nurse asked me to get.
25 So, the name of the drug in all three instances was
the same.



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Q. Is it your recollection that the doctor who requested the drug to be kept at the bedside asked for more than one ampule. Was there any discussion about quantity because you said a few moments ago some ampules.

A. Not specific quantity but he asked for some, he wanted more than one.

Q. All right. And how many did the nurse ask you to get?

A. She didn't specify how many, she just said to get some.

Q. All right. Mrs. Sui Scott as you know has testified here concerning the events of that day shift. She has testified, and this is found, sir, at Volume 119, page 7005 that she was the one who asked you to go and get the drug. Now, you have told us that you don't remember who it was.

A. Yes.

Q. Do you have any reason to disagree that it was Mrs. Scott, if she has suggested that she did. Do you have any reason to disagree with that?

A. I wouldn't disagree with her. I don't recall that it was her.

Q. That's fair enough, all right.



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And what did you do as a result of that request?

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A. I walked into the nursing station and there was a registered nurse or a nurse sitting at the nursing station and I asked her for some ampules of this specific drug.

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Q. Can you stop there for a moment.

A. Yes.

Q. How many ampules did you ask for?

A. I can't recall a specific number.

Q. I'm sorry.

A. I can't recall specifically how many I asked her for.

Q. Is it your recollection that you asked her for a specific number or that you simply asked her for some ampules of the drug?

A. I can't recall either way.

Q. All right. Do you recall who the nurse was who was sitting at the nursing station?

A. No, I don't.

Q. Was there only nurse or were there several?



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A. I believe there was more than one nurse in the nursing station.

Q. All right. When you say she was sitting at the nursing station we have heard that there was a front counter at the very front of the nursing station and towards the back there was some tables and some chairs?

A. Yes.

Q. Where was the nurse sitting to whom you spoke?

A. She was closer to the front.

Q. All right, nearer to the counter?

A. Yes.

Q. And she was sitting?

A. She was standing I believe.

Q. All right. Why did you yourself not go into the medication, either of the two that we know that were on that ward, and get the drug yourself?

A. I honestly can't recall. Perhaps it was because I wasn't as familiar with the medication room as they were and where the specific drug would have been kept and this is why I asked her.

Q. Had you been asked by the



Palmer, dr.ex.
(Cronk)

1
2 nurse in Justin Cook's room to get the drug yourself
3 or had she directed you to simply get it from someone
4 at the nursing station?

5 A. No, she suggested I go to
6 the nursing station and ask a nurse there to get it
7 for me.

8 Q. All right. And what happened
9 after you asked the nurse at the nursing station for
10 some of the drug?

11 A. I recall her going for it.
12 It seemed to me that she didn't have to go very far.
13 She didn't have to go out of the nursing station.
14 From my best recall the drug was sitting in the
15 station.

16 Q. Do you recall where it was
17 sitting?

18 A. No.

19 Q. Are you saying, Mrs. Palmer,
20 that the nurse of whom you made this request did not
21 go into either medication room to fetch the drug but
22 rather obtained it right there at the nursing station?

23 A. The best my recall is, yes.

24 Q. Do you remember where she
25 obtained the drug, physically where was it?

A. It seemed to me she turned



12 1
2 off to what would be her right side, which would be
3 close to the windows of the babies' room, that side of
4 the nursing station.

5 Q. All right. So, she turned
6 towards Room 418?

7 A. Correct.

8 Q. Did you see her reach into
9 a drawer or a cabinet of any kind to obtain the drug
10 or was it sitting on the counter. Can you help me as
11 to where it was?

12 A. To my best recall it was
13 sitting on a counter.

14 Q. And what did she give you?

15 A. She gave me two ampules.

16 Q. Do you recall what the name
17 of the drug was that she handed you?

18 A. No, I do not.

19 Q. Do you recall what the ampules
20 looked like?

21 A. Yes, they were of a moderate
22 size, not really size, but a medium size and brown
23 in colour.

24 Q. Brown in colour?

25 A. Yes.

Q. Are you certain in your own



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mind that they were ampules?

A. Yes, they were.

Q. What do you mean by an ampule,
Mrs. Palmer?

A. A glass bottle, a vial is a
glass bottle, it looks more the shape of a tube with
a little metal top on it; an ampule is total glass
which you have to snap to open.

Q. Are you clear in your own mind
that you were handed two brownish glass ampules,
brownish coloured?

A. Yes.

Q. Would you recognize the
ampule if you saw it again, or do you know?

A. I am sure I would.

THE COMMISSIONER: Perhaps if you just
gave them to Mrs. Palmer and asked her to get them
out.

MS. CRONK: I am going to get both
containers, sir.

THE COMMISSIONER: All right, that would
be better.

MS. CRONK: Sir, I note the time and
I will be another 15 minutes, 10 to 15 minutes with
Mrs. Palmer. Do you wish to break now?



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THE COMMISSIONER: Well, I thought
perhaps now that you have got us all excited --

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MS. CRONK: No, I am not suggesting
that we break before I hand her these two exhibits,
I am just noting the time and I don't know what your
plans are.

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THE COMMISSIONER: Well, as soon as
we get through this we can break for lunch, then we
can rise for lunch.

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MS. CRONK: All right.

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Q. Mrs. Palmer, I am going to
show you two boxes of various ampules that have been
marked as exhibits here. Can you identify for us
the drug that you were handed at the nursing station.
I am not asking you to guess, if you can do so with
certainty I would like you to help us. If you can't,
that's fine.

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A. You want me to look at the
name?

19

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Q. No, I don't want you to read
the name because you have indicated you don't remember
what the drug was.

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A. You are looking at just
the type of vial?

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Q. That's correct.



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A. Or ampule, rather. Similar to this.

Q. You are holding up a brown ampule and this one happens to have white lettering on it.

A. Yes.

Q. Is it correct that there are three brown-coloured ampules in those two exhibits?

A. Actually, there are four, there is another one.

Q. All right, there are four. The fourth one is smaller in size, is it not?

A. Correct.

Q. Are you sure that the one that you have selected, which happens to be furosemide is the size of ampule that you were handed?

A. I would say approximately, yes.

Q. And you are certain that it was that colour?

A. Yes, it was.

Q. But you don't recall now what the name of the drug was?

A. No.

Q. Do you remember what colour



Palmer, dr.ex.
(Cronk)

1
2 of lettering was on the ampule?

3 A. No, I don't.

4 Q. And you are certain in your
5 own mind that you were handed two?

6 A. That's correct.

7 Q. Thank you.

8 THE COMMISSIONER: Well, whenever you
9 want to.

10 MS. CRONK: Did you wish to break, sir,
11 or do you wish to complete her evidence?

12 THE COMMISSIONER: I thought it was
13 your idea.

14 MR. OLAH: Mr. Commissioner, Miss
15 Cronk's sketch is so marvellous we should have it
16 entered as an exhibit.

17 THE COMMISSIONER: Oh, yes, you are
18 quite right we should have it marked. What's the
19 number of that sketch?

20 THE REGISTRAR: 408.

21 ---EXHIBIT NO. 408: Sketch produced by Ms. Cronk.

22 MS. CRONK: Sir, one of my learned
23 friends has suggested in the last several weeks that
24 he can take a subtle hint and perhaps I can make one.
25 My suggestion is this. I can finish the examination
in chief of Mrs. Palmer in another 10 minutes and I



1
2 wish with your indulgence to do so.

17 3 THE COMMISSIONER: Oh. Well, all
4 right, there is no reason why we couldn't do that
5 but I wonder if we could just ask what the wishes
6 are. Is this your client, Miss McIntyre?

7 MISS McINTYRE: Yes it is, sir.

8 THE COMMISSIONER: How long would you
be with her?

9 MISS McINTYRE: I will be very brief.

10 THE COMMISSIONER: Could you just
11 raise hands, those of you who are present, what your
12 intention is to cross-examine.

13 MR.ROLAND: Well, I may have some
14 questions.

15 THE COMMISSIONER: I am just wondering
16 if it would be worthwhile trying to finish because
17 we have nothing else the rest of the day. Does anyone
18 want to take a vote on that, whether we will try to
19 finish and take a late lunch? I see a lot of heads
nodding. Anyone opposed?

20 All right then you proceed.

21 MS. CRONK: Thank you, sir.

22 Q. After you were handed the
two ampules, Miss Palmer, what did you do?

23 A. I returned to the room with
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them. I conferred with the doctor that I had actually brought in the correct drug. I held the vials - he was standing at the side of Justin Cook's bed.

4

Q. Right.

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A. And with the vials in my hand I showed them to him so he could see them and read to him what I actually had and asked him if this was the correct medication.

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Q. All right. Can we stop there for a moment.

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A. Yes.

12

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Q. While you were still at the nursing station and the nurse had handed you the two ampules, did you yourself look at them?

14

15

A. Yes I did.

16

Q. All right. For what purpose did you do that?

17

18

A. Just to re-assure myself that she had actually given me the drug that the doctor had asked me to bring in.

19

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Q. And were you so re-assured?

21

A. Yes, I was.

22

Q. Did you at that time read what was on the ampules?

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A. Yes, I did.

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Q. All right. And at that time
did the nurse give you a syringe or syringes?

A. No, she did not.

Q. Did you ask for one?

A. No.

Q. Was there any discussion
about syringes at all at that time?

A. No, there wasn't.

Q. How long after the start of
Justin Cook's blue spell, the start of the blue spell
was it when you went out to the nursing station and
were handed those two ampules, do you recall that?

A. I approximate about 15 to
20 minutes.

Q. All right. You have told
us that you then returned to Justin Cook's room and
you showed the doctor the ampules that you had?

A. That's correct.

Q. Was there only one doctor
in the room at the time or was there more than one
physician there?

A. I can't recall if there was
more than one.

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Q. Was the physician to whom you showed the drugs male or female?

A. Male.

Q. Do you remember who he was?

A. No.

Q. And what did you do when you showed him the drugs? Would you tell me that again please?

A. I read from the label of the ampule what the drug was, and asked him, "Is this what you want? Is this correct. Is this the correct medication?"

Q. And what did the doctor reply?

A. Yes, they were.

Q. Did he at that time ask you for a syringe or syringes?

A. No, he did not.

Q. Did anyone else?

A. No.

Q. Did you ask him whether he wanted one?

A. No.

Q. Was there any discussion about syringes at all?

A. None whatsoever.



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Q. What happened after you read out the name of the drug to the doctor and he said it was the drug that he wanted?

A. I placed the two ampules at the bottom of the bed, on the mattress, and let the nurse -- well, she was there anyway, she saw me do it. I just said, "I will place them down here. I will leave them here."

Q. Did the doctor actually look at the ampules himself or was he listening to you read it out?

A. He was certainly listening to me, he was glancing my way, you know, towards the vials, the ampules in my hand.

Q. How many nurses were in the room at the time?

A. I would estimate about three.

Q. Was one of the three nurses the nurse who was taking care of Justin Cook?

A. Yes.

Q. Was one of the nurses -- well, it follows from that that it could well have been the nurse who asked you to go and get the drug?

A. That's correct, she was there.

Q. Can you help me please, did you



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draw the drug up, either ampule, into a syringe before
you placed them on the bed?

A. No, I did not.

Q. Did you see a syringe near the
bed or on the bed?

A. No.

Q. Did anyone else ask you, apart
from the physician that you told me, did anyone else
ask you to go and get a syringe so the drug could be
drawn up?

A. No.

Q. Did anyone else go and get
one to your knowledge at that time?

A. Not to my knowledge.

Q. Did anyone else draw up the
drug in any fashion, either ampule, in your presence?

A. Not that I'm aware of.

Q. Why did you place the two
ampules on the bed?

A. To me that was the best place
to leave them. There wasn't much room left, the
crash cart was in the room and that was the best place
as far as I thought.

Q. And was it on Justin Cook's
bed?



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A. Oh, yes.

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Q. Was it at the foot end or the
head end of that child's bed?

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A. The foot end.

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Q. Was he still in the bed?

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A. Oh, yes.

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Q. Was the physician and the nurses
around the bed at the time?

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A. Yes, they were.

13

Q. Did you have any discussion
with any of the three nurses that you think were in the
room about the fact that that is where you were going
to put them?

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A. When I put them down, the nurse
who was standing right beside me, who was Justin Cook's
nurse, I did say to her, "I will put them right here."

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Q. And that is what you did?

19

A. Mm-hmm.

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Q. And that was at the foot of his
bed?

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A. That's correct.

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Q. What did you do after you placed
the ampules on the bed?

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A. I returned to my patients.

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Q. Did you remain in Room 418 for

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the balance of the shift?

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A. Yes, I did.

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Q. What time did you leave that
night?

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A. I would say approximately 7:30,
quarter to eight, I can't remember.

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Q. You told us that from the start
of Justin Cook's blue spell the time that passed until
you went to the nursing station to get the ampules was,
as you approximate it, about 15 to 20 minutes?

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A. That's correct.

12

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Q. Did you return from the nursing
station immediately back to 418 with the drug?

14

A. Yes, I did.

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Q. That would put you back in Justin
Cook's room with the two ampules of the drug at
approximately a quarter after or twenty after six,
about twenty after, take a few minutes to go and get
it and then come back?

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A. Right.

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Q. And you were there you think
until about 7:30 or quarter to eight?

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A. That's correct.

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Q. During that period of time, it
could have been as much as an hour and 15 minutes?



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A. Mm-hmm.

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Q. During that period of time before you left the room to complete your shift that night to go home, did you see anyone draw up either or both of those ampules into a syringe?

A. I can't recall.

Q. One way or the other?

A. No. I wasn't paying attention so I can't recall.

Q. It is possible that it happened? I take it is possible because you don't remember one way or the other?

A. It's possible but I really shouldn't even say that because I can't recall.

Q. Did you yourself do so?

A. No.

Q. Did you see anyone else tape either or both ampules or anything to Justin Cook's bed before you left the room that night at the end of your shift?

A. Not that I can remember.

Q. Again you can't remember one way or the other?

A. No, I can't.

Q. When you left that night at the



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end of your shift, did you observe any drugs or any ampules on Justin Cook's bedside as opposed to the bed itself?

A. I can't recall.

Q. During the balance of time after you brought the drugs back into the room to the time that you left, was there any other nurse or nurses in the room for the same period of time?

A. I can remember one nurse.

Q. What was she doing?

A. She was caring for the, the three remaining children, Justin Cook and the other two babies.

Q. Was it the same nurse that you had understood had been caring for Justin Cook earlier?

A. As far as I can recall, it was, yes.

Q. And during the time that you were still in the room until you left, did you have any discussion with her at all concerning either the two ampules that you placed on the bed or as to what was to happen to them or as to the drawing up of the drug, or as to any other matter concerning those two ampules?

A. No, I did not.



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Q. No discussion at all?

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A. No.

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Q. When you left that night you told us you didn't notice one way or the other whether anything was taped to the child's bed?

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A. That's correct.

7

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Q. You didn't notice whether anything was on the bedside of that child's bed one way or the other?

9

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A. No.

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Q. When you left, did you indicate to anyone that you had placed the two ampules of a drug on the child's bed, that they should attend to it, make sure what was done with it, as the doctor ordered?

15

A. No, I did not.

16

17

Q. You didn't have any discussion with anyone before you left?

18

A. No.

19

20

21

Q. During that period from the end of Justin Cook's blue spell until you left, the end of your shift that night, did you see anyone giving Justin Cook any medication of any kind?

22

A. Not that I recall.

23

Q. One way or the other?

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A. Either way.

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Q. Do you know, Mrs. Palmer, who drew up, in fact if it was done, who drew up those two ampules or any drug that was in the syringes that may have been taped to the end of Justin Cook's bed?

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A. No, I don't.

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Q. Do you have any information or knowledge about that at all?

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A. None whatsoever.

10

Q. Do you know what happened to the two ampules that you left on his bed?

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A. No, I don't.

13

MS. CRONK: Thank you very much. I have no further questions, sir.

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THE COMMISSIONER: Thank you. Miss McIntyre?

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MS. MCINTYRE: I have no questions at this time.

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THE COMMISSIONER: All right.

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Yes, Mr. Brown?

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MR. BROWN: No questions.

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THE COMMISSIONER: Anyone?

22

MS. RAE: No questions.

23

MS. CECCHETTO: No questions.

24

MR. ROLAND: Just one question.

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CROSS-EXAMINATION BY MR. ROLAND:

Q. You may have answered this question already, Mrs. Palmer, but I must have missed it. When you brought the two ampules back into the room and you say you put them at the end of Justin Cook's bed.

A. Yes.

Q. Did anybody acknowledge you doing that, were there people there that saw you do it, or say thank you, or recognize what you were doing?

A. The nurse that was standing directly to my right side.

Q. Yes.

A. Which as I recall it as being Justin Cook's nurse for the day, although I can't remember who she was. She most assuredly knew where I was putting them. She was standing right beside me and there was so little room there I just put them right down there and she knew they were there.

Q. So there was no doubt in your mind that at least that nurse present with you knew precisely what you were doing?

A. That's correct.

Q. And were there doctors then present as well?

A. There was at least one doctor there.



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Q. Would he also have recognized
what you were doing?

A. Mm-hmm.

Q. Did you say yes?

A. He should have.

MR. ROLAND: Thank you.

THE COMMISSIONER: Yes, Mr. Olah?

MR. OLAH: No questions.

MR. LABOW: No questions.

THE COMMISSIONER: Now you still have
a chance to reply to that lengthy cross-examination
by Mr. Roland, Miss McIntyre.

MS. MCINTYRE: I think I will resist
the temptation.

THE COMMISSIONER: All right.

Ms. Cronk?

MS. CRONK: I, sir, have at least an
hour. Mrs. Palmer, thank you very much for your
assistance.

THE WITNESS: You are welcome.

THE COMMISSIONER: Thank you indeed.
I think you have established a record for us as a
short witness and it is a good record, it is a good
record I can tell you. Thank you.

--- Witness withdraws



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MS. CRONK: Excuse me, Mr. Commissioner, although the witness is being excused there is one other matter that I would like to attend to now if I could.

THE COMMISSIONER: Yes, all right.

MS. CRONK: Ms. McIntyre has been kind enough to provide Commission Counsel with a letter which deals with discussions that she has had with certain of her clients concerning the very issue as to who drew up the ampules of drugs and taped them to Justin Cook's bed. I would like to read the contents of the letter formally into the record and then ask you to accept it as an exhibit.

THE COMMISSIONER: It is from Miss McIntyre?

MS. CRONK: I am sorry, it is from Ms. McIntyre and it is addressed to myself, and it is dated May 1, 1984:

"Please be advised that we have checked with the following of our clients who worked on the day shift of March 21st, 1981, the shift preceding Justin Cook's death. Marianne Bracewell, Marie Mandal, Margot Ober. All three nurses



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"confirm that it was not they who either drew up the Inderal in accordance with Dr. Jedeikin's order, or placed medication at the patient's bedside. Accordingly these nurses can give no helpful evidence on this point. Yours very truly, Elizabeth McIntyre."

I would ask you, sir, to accept this letter as an exhibit. In light of its contents it is not the intention of Commission Counsel to call any of those women to give evidence on this point.

I would, however, ask Ms. McIntyre to clarify for you, if indeed she did mean Dr. Jedeikin's order, or was she referring inadvertently to him when she meant Dr. Kantak's order that the drug be drawn up and left by the bedside.

MS. MCINTYRE: It would be the order of Dr. Kantak, yes.

MS. CRONK: Would it be appropriate, sir, to mark that as an exhibit?

THE COMMISSIONER: Yes, all right. Thank you. 409.

--- EXHIBIT NO. 409: Letter from Ms. McIntyre to Ms. Cronk dated May 1, 1984.



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THE COMMISSIONER: Is there anything
else then before we --

MS. CRONK: Thank you, sir, I have no
other evidence.

THE COMMISSIONER: Anyone else? Then
if no one else has anything, until 10 o'clock on
Monday. Who is scheduled to be the first appearance?

MS. CRONK: As I understand it
Mrs. Hines is to be the first witness Monday morning
at 10 o'clock.

THE COMMISSIONER: Yes, all right,
Mrs. Hines at 10 o'clock on Monday morning.

--- Whereupon at 1:00 p.m., the hearing adjourned
until Monday, the 7th of May, 1984, at
10:00 a.m.

